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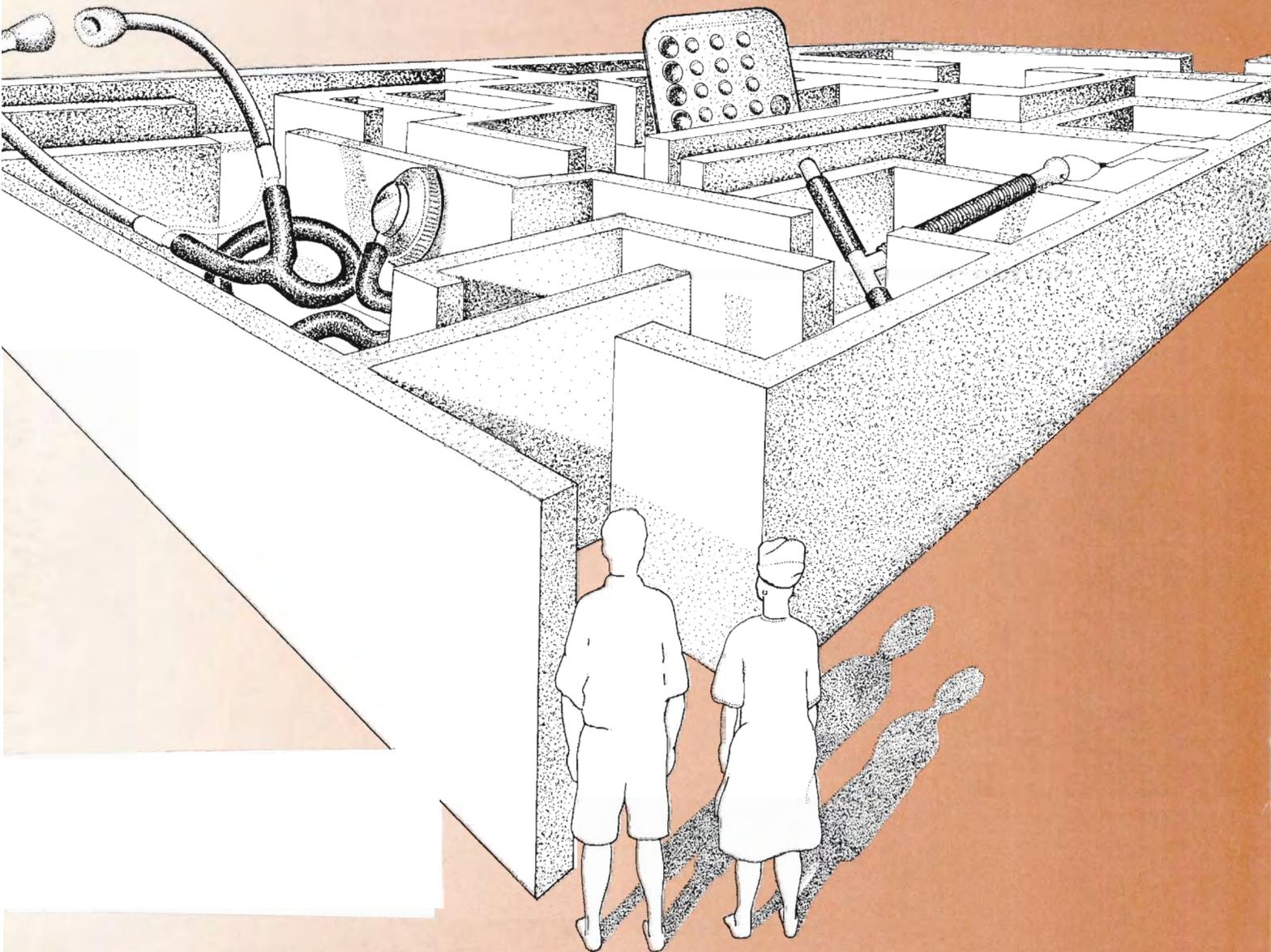
FAMILY HEALTH INTERNATIONAL, VOL. 13 NO. 3, MARCH 1993

Improving Access to Contraception

THE PILL: HOW MUCH
SCREENING IS ENOUGH?

IUDs: IMAGE VS.
CURRENT KNOWLEDGE

CONTRACEPTIVE SEMINARS
KEEP PROVIDERS INFORMED



News Briefs

FRANCOPHONE AFRICA MOVING TOWARD NORPLANT USE

Senegal has become the first nation in francophone West Africa to introduce Norplant, the contraceptive implant, as an option in its national family planning program.

The introduction of Norplant in July 1992 follows collaboration between the Ministry of Public Health and Social Action (MPH/SA) and the University of Dakar Hospital, where a clinical trial on Norplant has been under way since 1986. An introduction strategy included assistance from FHI, the Johns Hopkins Program for International Education in Reproductive Health (JHPIEGO) and the Association for Voluntary Surgical Contraception (AVSC).

The strategy has included training in clinical and



counseling procedures for midwives and physicians in the use of Norplant, which provides five years of contraception through six match-stick-size capsules inserted just below the skin of a woman's arm.

The effort also includes a colorful pamphlet which explains the method to clients, prepared by MPH/SA, Program for Appropriate Technology in Health (PATH), Health-Com and FHI, using funds from the U.S. Agency for International Development.

In the first four months of Norplant services, 410 women received the contraceptive, says Dr. Isseu Touré, deputy director of the MPH/SA Maternal Child Health and Family Planning Division.

Elsewhere in francophone Africa, health officials in Mali have granted regulatory approval for the use of Norplant. A strategy for its introduction is expected to be prepared this year.

AIDS PREVENTION NEEDS U.S. \$2.5 BILLION WORLDWIDE

The world needs to spend at least 20 times more on the global fight against AIDS in developing countries, according to a recent estimate by the World Health Organization (WHO).

WHO figures show that in 1991, governments and agencies worldwide spent about U.S. \$120 million in developing countries on AIDS prevention. WHO conservatively estimates that at least U.S. \$2.5 billion should be spent to have any significant impact on slowing the epidemic.

"Every hundred dollars spent now will save millions later," says Dr. Michael Merson, director of the WHO Global Programme on AIDS. "What the world community commits to preventing AIDS in the next couple of years will directly affect the course of the epidemic over the next two to three decades."

The amount needed is less than 3 percent of what the world's nations currently spend on their militaries.

The money is needed for educational campaigns supporting safer sexual practices and to distribute condoms. WHO estimates that

mass media strategies using television, radio, newspaper or posters cost between U.S. 6 cents and 32 cents per person reached. They estimate the cost of promoting condoms at between U.S. 2 cents and 30 cents per condom, depending on the cost of the condom and the number of condoms distributed.

WHO recommends a package of AIDS prevention measures that includes projects in schools, person-to-person education, media campaigns, large-scale distribution of condoms and treatment for sexually transmitted diseases.

SHE'S JUST AS GOOD, INDIA'S LETTERS SAY

A cancellation postmark reading "A daughter is as good as a son" is being stamped on mail in India, a recent effort by the government to change the country's long-standing tradition of gender preference.

A popular attitude favoring sons over daughters is often cited as a key obstruction to sound family planning in India. The low value placed on daughters has been linked with high rates of female infanticide and childhood mortality among girls.

"Women keep having children not because they want more children, but because they need more sons," says Seema Chouhan of Washington, former executive director of Prerana, an Indian voluntary organization dedicated to improving women's lives through better family planning and other means. "Simply, sons are assets and daughters are

liabilities for Indian families."

In 1990, the South Asia Association for Regional Cooperation, which includes India among its seven member nations, declared the new decade as "Decade of the Girl Child," calling attention to problems female children face in Asia.

The Indian government has supported other initiatives to improve the status of girl children, including advertising campaigns and grassroots literacy and skills training programs for young women.

(More news briefs on page 30)

**A DAUGHTER
IS AS
GOOD AS A SON**

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JIM MCMAHAN / FHI

DR. HALIDA AKHTER

A Special Obligation - Access to Contraception

*By Dr. Halida Akhter
Bangladesh Institute of Research
for Promotion of Essential and
Reproductive Health*

DHAKA, Bangladesh — In rural areas of this and other countries, paramedics go from house to house providing injectable contraceptives that prevent pregnancy for three months. In small shops, people can get oral contraceptives without prescriptions. Trained outreach workers insert IUDs in poorly served urban areas and hard-to-reach villages, through satellite clinics and home insertions.

Unfortunately, such innovative means of making contraceptives easily available are the exception rather than the norm — often because of barriers from the medical community itself, which has limited exposure to public health issues and perspectives. We doctors in developing countries have a special obligation to help increase access to safe and effective contraception as quickly as possible.

When policy-makers plan the “shoulds” and “musts” for delivering family planning services, we must remind them to take into account the benefits and risks involved as well. We must help save a woman from the inherent health risks of pregnancy, when pregnancy is unwanted. To do so, we must find ways to improve her access to contraceptives.

At the beginning of my career in family planning, I was a teacher and a medical officer at a paramedic institute. My experience convinced me that properly trained paramedics can provide some services traditionally given by physicians in clinics — and they can do this just as safely and effectively as physicians. It is critical that governments examine which services could be delegated to paramedics.

Given proper training and adequate conditions and supplies, paramedics perform very well. Where paramedics such as nurse practitioners and nurse

midwives are allowed to insert an IUD, for example, they often do it more carefully than a highly qualified doctor. This is because they feel honored to have been delegated this responsibility and are conscientious about carrying out the procedure well. Also, highly skilled doctors have to be knowledgeable and skilled in many different tasks and do not perform IUD insertions regularly.

In Indonesia, nurse practitioners are performing IUD insertions, and public health nurses are trained to insert Norplant in Nepal. Training staff report that these paramedics listen very intently and carefully, and then they perform well when given the new responsibility.

In some countries, the medical community is cautious about expanding access through provision by paramedics. Physicians can be quite protective of their own territory, holding that only physicians should be the prime service providers.

In Egypt, doctors are closely involved in developing the family planning program. Consequently, they feel a certain degree of ownership. This can make them reluctant to delegate the provision of services to any other types of providers. Only obstetrician/gynecologists can insert IUDs and give injections in Egypt. In some countries, medical professionals have been resistant to the idea of delegating some services to paramedics, even in remote or rural areas where there are few physicians. As a practical consequence, this means many rural women are denied access to services that they need or want.

In Bangladesh, however, the medical community understands that if they don't give family planning responsibilities to paramedics, then the doctors have to do it, yet doctors generally are unavailable in rural areas. Paramedics here are trained to insert IUDs and for a long time have been doing so.

CLEAR GUIDELINES

Another major barrier to increasing use of contraceptives is the lack of clear, specific guidelines. Without them, providers do not know what they should do, and this often results in overly conservative behavior. It is helpful for international agencies to disseminate research results that show that a method is safe and effective or research that underscores the good safety record of using paramedics or non-clinic sites to provide services. This record can be used as policy-makers develop specific guidelines.

I recommend two sets of guidelines: one geared to the senior program manager level, and one to the providers in the field. Guidelines for senior managers should address quality of care aspects that good managers need to monitor continuously. Those issues should be translated into step-by-step instructions that can be used at the clinic level.

At the field level, different guidelines are needed, which can be conveyed through various techniques. A reference wheel, for example, is a very useful device for managing side effects. If a client has a bleeding problem, the worker would give her counseling and iron tablets if the problem were only slight. If bleeding is excessive, then the worker is directed by the reference wheel to give her the appropriate medication and treatment. Such problem-specific or method-specific guidelines can be provided on a reference wheel or similar device that incorporates age and various reproductive health factors.

Writing guidelines is not an easy task. Too many "musts" and "shoulds" can be a barrier, especially when applied in the satellite clinic setting, where providers have to carry in everything in the morning and carry it back at night. They need to provide their service in an optimum way and maintain safety of the procedure with minimal equipment and materials. Therefore, basic safety points and ways to maintain high quality care must be known and practiced.

Easing restrictions on when various methods can be used would improve access. In many countries, if a woman comes into the clinic and it has been more than seven days since her last menstrual period, a provider cannot give her a contraceptive. Instead, the provider tells the woman she has to come back next month or return in two or three weeks to take a pregnancy test.

This practice is designed to assure providers that the woman is not already pregnant. Instead of this procedure, wouldn't it be better to serve this woman during that visit? Take her medical history and find out the date of her last intercourse. Then you can provide her with a suitable method, knowing that there is no risk

or only a very small chance of pregnancy. In Bangladesh, for example, we can give a woman an IUD 10 days after her period, but some countries are very strict in saying that a woman must wait, telling her to come back for an IUD immediately after having her menses.

Some clinics require follow-up visits after IUD insertion at one, two, three and six months, a schedule that is based on clinical trial protocols, not on safety needs. Such a schedule gives clients the impression that they need to come back and be seen often in order for this method to be safe and effective. That alone will deter potential users, as will the inconvenience of so many physical examinations.

Other women who hear about the follow-up requirements will doubt whether they would be able to leave their homes or have the money to travel to a clinic. Program managers and policy-makers must understand the impact such inconveniences can have. If an inconvenient procedure is not necessary for a woman's safety, then it should not be required.

TOO MANY TESTS

Providers also need better guidance regarding screening procedures. When women have to go from one lab to another lab to get tests done, this is a barrier to contraceptive use. Clients will tell you they consider it a disadvantage or it is too difficult or too cumbersome

to accept the method.

We have to understand clearly how the screening procedures are viewed by the people we serve. This can be particularly cumbersome with oral contraceptives, which some countries now make available with no prescription or tests at all.

In some countries, especially where women have little power in relationships with men, a husband's consent is mandatory for some methods. Signatures of husbands are required for a new method or sterilization. For a man to get a vasectomy, he does not need a wife's consent; yet for a wife to get a tubal ligation, she needs her husband's approval.

Ideally, if a woman tells me that her husband agrees to a new method or a sterilization, I should get her signature — not his. That should be enough. Instead, in Bangladesh and Pakistan, we tell her that she has to go back home and get her husband's signature.

Dr. Akhter, a physician, has worked in family planning service delivery projects throughout the world for the World Bank, the World Health Organization and the Ford Foundation. In 1986, she returned to her native country to become executive director of the Bangladesh Institute of Research for Promotion of Essential and Reproductive Health, a research and training program.



BERYL GOLDBERG

YOUNG MOTHERS GATHER WITH THEIR CHILDREN IN DHAKA, BANGLADESH.

Attitudes, Regulations Hinder Use of the Pill

Unnecessary screening discourages many women from using OCs, despite a long history of safe use.

In the United States, a sexually active teenage girl may decide not to use the pill because she fears the pelvic exam required for a pill prescription.

In India, some doctors discourage healthy women from using oral contraceptives because they believe incorrectly that the pill causes cancer. And in Japan, a woman simply would be unable to obtain oral contraceptives because the pill is illegal.

All of these women could safely use the pill. Yet questionable medical attitudes, regulations or practices keep them and many women around the world from using one of the most convenient and effective contraceptive options available.

While more than 70 million women currently use the pill, including 40 million in developing countries, oral contraception is not as widely used as it could be, in large part because it is misunderstood by many within the medical community.

In the 30 years since its debut, the pill has become the most studied family planning method in history. Yet misperceptions about the pill's safety record persist in the medical community.

A growing number of experts believe some medical practices and attitudes that limit access to the pill are scientifically unjustifiable, especially when compared with the risk of pregnancy.

"The pill, as with all systemic contraception, is a medication used in a prophylactic manner among healthy women during their reproductive years," explains Dr. Ted King, FHI president. "As such, the pill needed to be tested very thoroughly for safety, and so what were necessary precautions and prescribing practices 30 years ago when we knew so little about the pill were overly conservative and are unnecessary obstacles to access today."

"The risk is minimal for most women, but even for those women with risk factors, the dangers must be weighed against the high risks of pregnancy and childbirth," says Dr. King, whose specialty is gynecology and obstetrics.

CONFLICTING ADVICE

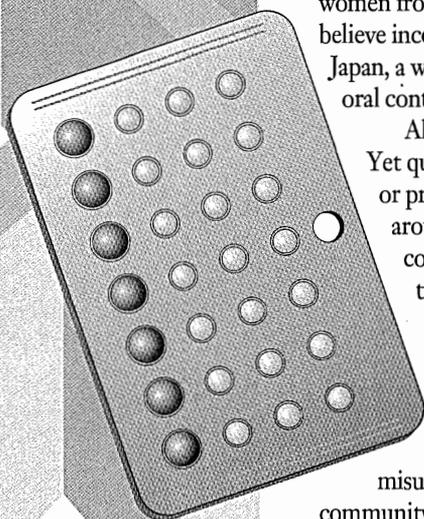
Barriers to pill use exist, from the international policy level to the service delivery level. "Access to OCs varies from one country to another and from one service delivery system to another," says Dr. Carlos Huezo, International Planned Parenthood Federation's medical director.

Prescribing practices vary even in countries with widely available services, says Dr. Huezo. For instance, a country may limit access for specific groups, such as unmarried women. In the United States, he notes, economic or legal barriers may block access to the pill. Teenagers may not be able to afford services required to obtain the pill or may need parental consent even when services are free.

Other barriers, such as the role or status of women within a culture, may be crucial factors that limit access to the pill or any other family planning service, suggests Dr. Marcia Angle, clinical officer for the Program for International Training in Health (INTRAH). Such cultural and social barriers are often beyond the power of health providers to change. "But medical barriers are remediable," she says. "These are access problems that we can do something about."

The problem among health providers can be appreciated from a recent survey of eight international organizations' family planning guidelines. The review found a variety of conflicting rules about eligibility criteria and prescribing practices for many contraceptive methods, including the pill, according to FHI researchers.¹

Yet there are also encouraging signs, says Dr. Angle. In the last few years, many countries have revised policies to improve access to family plan-





BERYL GOLDBERG

A BANGLADESH CLINIC WORKER, LEFT, ADVISES A CLIENT ABOUT THE PILL.

ning. For example, Botswana, Burkina Faso, Cameroon, Tanzania, Togo and Uganda have revised policies to allow distribution of birth control methods, including the pill, to unmarried adolescents.²

WHO SHOULD USE THE PILL?

For the majority of healthy, nonsmoking women, the pill is extremely safe, says Dr. Herbert Peterson, Women's Health and Fertility Branch chief for the U.S. Centers for Disease Control. "Today's formulations of the pill offer much lower doses than earlier versions," he says. "The pill is also safer today because we know that it should be avoided by women in one high risk group — smokers who are over age 35."

Current scientific evidence suggests that many of the conditions that were once absolute contraindications for pill use now need only be viewed as signals for closer monitoring.

Unfortunately, many health care providers around the world still use unnecessary exclusion criteria, often codified in national family planning policies and service delivery guidelines. Such criteria are based largely on outdated information or a misunderstanding of the pill's safety record regarding cancer and

cardiovascular disease.

Unwarranted contraindications—

Some contraindications for the pill are simply unwarranted, according to current scientific knowledge. Restricting the use of the pill to women who have already given birth, for example, is a rule that was rooted in early fears that the pill might cause sterility or be blamed for such by users who were sterile for other reasons. In fact, the pill may protect fertility by guarding against upper reproductive tract infections due to gonorrhea.

The still commonly held notion that pill users need a "rest period" after using the pill for some time apparently stems from a 1960 decision by the U.S. Food and Drug Administration (FDA) to approve the pill for only a two-year period pending clinical data not available at the time. In fact, there is no medical reason why a woman should interrupt or discontinue use after any given period of time, unless she is experiencing serious side effects or wishes to become pregnant.

Similarly, current instructions in the United States for use of progestin-only oral contraceptives carry incorrect advice about contraindications because they include warn-

ings that apply to pills that contain estrogen. Progestin-only pills (POCs) are ideal for nursing women because they do not affect lactation, yet they currently carry FDA labeling for OCs that contain estrogen. That means POCs are contraindicated for the very group for which the method was designed. FHI is assisting the FDA in writing new labeling designed specifically for POCs.

Exaggerated contraindications —

Other contraindications for the pill are based on a medical rationale but are often taken out of context. Conditions that warrant some consideration, often labeled "other considerations," are interpreted as absolute contraindications by some field workers. Diabetes or migraine headaches, for instance, usually listed as "relative" contraindications, are often treated as absolute. Women suffering from



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A NURSE VISITS A MOTHER AND CHILD AT THEIR HOME IN MONTEVIDEO, URUGUAY, TO GIVE FAMILY PLANNING ADVICE.

either of these conditions might need closer monitoring but should not be denied the option of using the pill.

Imprecise contraindications — Some contraindications are too general and tend to be followed imprecisely. “Headache” and “chest pain,” common items on checklists at clinics and community-based distribution programs, often are interpreted too conservatively. In some settings, any woman with a headache or palpitations in recent memory may be denied OCs or sent to a clinic for evaluation.

An even worse scenario, says Dr. Suman Mehta, a reproductive epidemiologist with the World Health Organization (WHO), is asking about “palpitations” by saying “Do you feel your heart pumping?” — a question whose accurate response would exclude all women from pill use.

Finally, some contraindications need to be qualified because they are warranted only for certain groups of women. The warning about “irregular vaginal bleeding” that is too frequent or too heavy should be limited to women over age 35, when such bleeding could indicate endometrial cancer. Infrequent bleeding occurs commonly among healthy young women and, in fact, the pill is commonly prescribed to regulate bleeding. If frequent, heavy bleeding occurs at any age, a diagnosis should be made before OC therapy begins.

“Only a very few women need to be restricted from using the pill,” says Dr. Mehta. “That is not the message that most family planning workers have today. We must devel-

op simpler criteria for identifying who should not use the pill.”

WHO and other international organizations have launched a joint initiative to standardize eligibility criteria at the international level.

Meanwhile, family planning providers in sub-Saharan Africa already have an easier time, thanks to new simplified instructions for service providers. In an effort to reduce confusion about contraindications, INTRAH, a U.S.-based group working in Africa, has revised its *Guidelines for Clinical Procedures in Family Planning* to eliminate the complex system of classifying contraindications.

Instead of using distinctions such as “absolute” or “relative,” INTRAH simply describes who is and is not a good candidate for various methods, explains INTRAH’s Dr. Angle. Because “absolute and relative contraindication” often have a very negative and inflexible connotation, especially among field workers, these terms have been replaced with “primary and secondary precautions” to indicate that consideration of a woman’s circumstances is important.

PROVIDING THE PILL

Many women, especially young women at risk for unintended pregnancy, might use OCs if they did not have to see a doctor or go to a clinic to get an examination or have blood drawn. More also might use the pill if it were easier to get a new supply.

Current prescribing practices in many countries, both to initiate and continue use, play a major role in limiting access to the pill. Women wishing to obtain the pill often are

required to undergo a battery of tests during initial screening, including frequent pelvic examinations and unnecessary and costly laboratory tests. Then, in many countries, women receive only an initial one- to three-month supply with instructions to return for more tests in order to get more pills.

These practices may be good preventive medicine for overall reproductive health, say experts, but they are not proper prerequisites for OC use. Too often they impose fear, discomfort or inconvenience that deter many women from using the pill.

Japan offers a related example of how access to the pill can be impeded by unrelated health goals. In an effort to encourage condom use in the face of the AIDS epidemic, a government panel in 1992 decided to keep that country’s long-time ban on the pill even while acknowledging that studies show oral contraceptives are safe.

Dr. Allan Rosenfield, dean of the Columbia University School of Public Health, believes it is inappropriate to make desirable yet unrelated health goals a requirement for getting the pill. “I’d like all women — using pills, using condoms, using no contraception — to have a Pap smear every year, but is it appropriate that this test be a condition of pill use?”

Yes, say some women’s advocates in the United States. The move to relax restrictions to OC access may increase imprudent and unsafe contraceptive provision, cautions Judy Norsigian of the Boston Women’s Health Book Collective.

“Hormonal methods are not for every woman,” says Norsigian. “It is absolutely essential that women get the proper screening and counseling so that they aren’t exposed to inappropriate risks.”

She also criticizes the trend in many places toward downgrading “contraindications” to “precautions.” “When you start using the word precaution, you give too mild a message,” she says.

If OCs were non-prescription, women who already do not get adequate information about health effects would get even less, she says. “Women need to be fully informed so they can make an informed choice,” she says.

But for much of the world, such tests restrict access both in terms of cost and inconvenience, says Dr. Mehta. “They also place an extra burden on already overloaded services in many developing countries where human, financial and physical resources must be used optimally.”

Recent research by WHO suggests that prescribing practices that are too restrictive are widespread.

Citing an unpublished WHO survey of 60 family planning clinics worldwide, Dr. Me-

hta says that detailed examinations and testing, such as blood and urine tests, are routine practice in some places, both for initial screening and at frequent follow-up visits.

Not only are blood tests costly but they are not helpful in identifying women who should not use the pill, according to 1990 FHI findings in francophone Africa. As a result of this research, the governments of Senegal, Togo and Cameroon dropped requirements for lab tests.³

Yet such requirements are the law in more than half of 32 African countries.⁴ These requirements assume that a doctor's expertise and physical examination are necessary to identify a woman who has contraindications to OCs. Research suggests otherwise.

An evaluation of a community-based pill distribution program in Mexico showed the health of women who had obtained pills

through non-medical channels was as good as those who had received them through clinics.⁵

In many countries, a simple checklist has been used successfully by nurses, midwives and others to rule out women at risk for using the pill, despite the problem that questions can be too general and open to broad interpretation.

The Mexican study suggested these questions can be much more specific in places where women are well informed about their health status with respect to high blood pressure, blood sugar, anemia, angina and past cardiovascular disease. For instance, rather than asking about unusual shortness of breath or severe chest pains, the worker could ask women more directly about history of heart disease or liver disease.

SMART START

While some countries have moved to

ease rules for OC distribution, the United States has been slow to follow. As currently labeled by the FDA, an OC prescription requires a yearly physical and Pap smear.

Dispensing the pill over-the-counter in the United States is not likely to occur soon, but efforts to make the pill more accessible are gathering momentum.

Smart Start, a pilot project conducted by the Family Planning Council of Southeastern Pennsylvania, allowed 390 adolescents at three clinics to postpone a pelvic exam and routine blood tests for up to six months after they began taking the pill. Blood drawing, rather than the pelvic examination, posed the greater fear among adolescents. They were almost twice as likely to delay the blood tests as they were the pelvic examination.

Based on this research showing that de-

BENEFITS AND RISKS OF THE PILL

Protection — Data suggest that oral contraceptives (OCs) protect against development of two potentially fatal diseases: ovarian and endometrial cancer. The pill also protects against three conditions particularly relevant to the developing world: pelvic inflammatory disease (PID), ectopic pregnancy and anemia.

Cardiovascular disease — Concerns about the relationship between the pill and cardiovascular disease stem from research conducted during the 1960s and 1970s, when pills contained significantly higher doses of steroids than today's formulations.

More recent studies have shown that newer formulations in combination with better prescribing practices have reduced the relative risk. Experts believe that the risk of cardiovascular diseases, such as heart attack and stroke among pill users, is largely limited to women over age 35 who smoke.¹

Recent research on low-dose pills (those with 30 to 35 micrograms of estrogen and 1 milligram of progestin) even suggests a lower risk among low-dose pill users compared with high-dose users for venous thromboembolic disease, a blood-clotting disorder.² A World Health Organization study under way in 15 developed and developing countries should provide more information on the magnitude of cardiovascular risk for women who use today's low-dose pills.³

Breast cancer — While concerns about the link between cardiovascular disease and OCs have diminished, fears about the association of OCs with breast cancer persist. Research to date shows no overall increased risk of breast cancer among women who have ever used OCs. There is, however, conflicting evidence regarding a small group of women — those who use the pill for a long time at a young age. For these women, there is concern that the pill may slightly accelerate onset of the disease during their younger years (when the disease is uncommon).⁴ There is no evidence of increased risk of breast cancer diagnosed in women after menopause, when breast cancer most commonly occurs.

Available breast cancer data may have little relevance for women in developing countries, since the research so far has followed only women in developed countries like the United States. Also, some experts believe that the risk of breast cancer in the United States, for example, may be particularly high because of diet and other environmental factors.

Cervical cancer — A more worrisome question about the safety of OC use is its association with cervical cancer. Death from cervical cancer is significantly more common in developing countries where women are less likely to be screened regularly for the disease. The link between the pill and cervical cancer remains controversial. Some experts believe that it can be attributed to the fact that women on the pill are screened more regularly and their cancers are found sooner. Nevertheless, the concern that long-term OC users may be at greater risk for cervical cancer makes it advisable that OC users receive regular cytologic screening (Pap smears) when adequate treatment and follow-up facilities are available.

— Sara Townsend

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ferring an examination improved access for sexually active teenagers without diminishing quality of care, and on continuing evidence that these exams deter some young women from seeking the pill, the Planned Parenthood Federation of America's (PPFA) national medical committee in 1992 recommended that PPFA's 900 affiliates across the United States offer women the option of delaying an examination for up to three months.

"We have been holding young women hostage to a procedure they often fear when it isn't necessarily relevant to whether they're good candidates for the pill," says Kara Anderson, PPFA medical affairs director. "This [recommended practice] lets them get used to the idea of having an examination, and gives us a chance to counsel them."

Required examinations provide gynecological screening where high prevalence of sexually transmitted diseases (STDs) is a

problem, acknowledges Anderson. "If an STD does go undetected for a few months, which is worse: that, or having a young woman get pregnant and have an STD too," she says, noting that the most prevalent STDs are asymptomatic and may not be detected by pelvic exam.

Anderson credits the success of Smart Start to a strong emphasis on counseling. Indeed, fear that women will not get adequate counseling is a common concern raised about over-the-counter sales of the pill.

Many experts would agree that counseling is very important, but good advice does not require a medical examination.

Research indicates that non-physicians can be trained to provide adequate counseling, notes FHI's Dr. Linda Potter, an expert on oral contraceptive compliance. "It is good counseling, and not exams and blood tests, that should be required for using the pill," she says.

—Sara Townsend

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BERYL GOLDBERG

IN BURKINA FASO, POLICIES HAVE BEEN CHANGED IN RECENT YEARS TO ALLOW DISTRIBUTION OF CONTRACEPTIVES, INCLUDING THE PILL, TO UNMARRIED ADOLESCENTS.

Comparing Quality of Care with Contraceptive Access

Family planning programs should offer clients access to high-quality care, through a broad range of contraceptive services and follow-up care as long as clients need it.

"Quality of care" has been defined by Judith Bruce, senior research associate with the Population Council, in a six-part framework. This model, also known as the Bruce framework (published in 1989 as Population Council Programs Division Working Paper No. 1), is recognized among many family planning providers as an important tool for measuring quality of care.

The framework emphasizes clients' need to have a broad range of contraceptives to choose from, as well as to be informed about their options so they can make an educated choice.

The model also states that providers of family planning services need to be technically competent — up-to-date in both knowledge and skills — and that they should treat clients with dignity, offering services in ways that are culturally appropriate and acceptable to clients.

Finally, the framework encourages family planning programs to provide follow-up care and to maintain adequate supplies of contraceptives for as long as clients need them.

Others in the family planning field, spearheaded by a U.S. Agency for International Development working group to improve access to contraception, have sought to improve services from another angle. They have identified a range of common barriers to contraceptive care, especially those that occur within the provider or medical community. Requiring too many physical examinations in order to get a contraceptive method is an example. Also addressed are intangible matters that are more difficult to measure, such as providers' attitudes.

When new contraceptive methods are introduced, many family planning programs impose very cautious eligibility criteria — such as refusing IUDs to women who do not already have children. After the safety of a contraceptive method becomes well known, some of these medical precautions remain in place even though they are no longer appropriate, thus constituting barriers to family planning.

Some medical providers view these measures as ways of protecting the individual's health, and question whether quality of care can be maintained if they are removed. But denying contraceptives to clients who want them and can safely use them also denies them quality of care. Efforts to improve quality of care while also reducing barriers to contraceptive use are complementary — both seek the same goal of easy access to high-quality contraceptive care.

In the list to the right, the six elements of the Bruce framework are shown in bold. Below each are listed several examples of unnecessary medical procedures which inhibit quality of care as described by the heading. Removing or reducing these barriers would enhance the quality of contraceptive care.

—Marguerite Rogers

SIX QUALITY OF CARE ELEMENTS AND MEDICAL BARRIERS THAT INHIBIT THEM

1. Choice of methods

MEDICAL BARRIERS

- age and parity restrictions for OCs, IUDs, sterilization
- excessive tests for OCs
- limits to number of OC packs a clinic will provide at a time
- outdated contraindications for OCs, IUDs
- provider bias against hormonal and other methods
- some methods not approved for use in some countries

2. Information to users

MEDICAL BARRIERS

- providers biased against particular methods (IUDs, OCs) don't promote or even tell clients about these methods
- providers who are not up-to-date cannot keep clients up-to-date
- providers may withhold information on side effects

3. Competence of providers

MEDICAL BARRIERS

- lack of up-to-date service delivery guidelines
- lack of refresher training
- client care varies between providers
- providers require outdated, unnecessary tests
- limits to who can provide services

4. Client-provider relations

MEDICAL BARRIERS

- limits to who can provide services means clients may not be able to work with someone they trust (i.e., a female nurse)
- clients lack confidence in providers who are not knowledgeable about, and competent to provide, a range of methods

5. Continuity of care

MEDICAL BARRIERS

- excessive follow-up visits required
- limits to who can provide services
- limit to supply of OCs provided at a time
- clients not adequately counseled on what to expect with contraceptive use

6. Appropriateness and acceptability of services

MEDICAL BARRIERS

- excessive and repeated tests and exams required (blood pressure, pelvic, pap smear)
- age and parity requirements unnecessarily strict
- start time of method restricted unnecessarily

—Dr. Karen Hardee

Today's IUDs Offer Safe, Effective Contraception

Incorrect impressions about safety and other concerns limit IUD use by clients and providers worldwide.

When inserted properly in women in monogamous relationships, today's intrauterine devices (IUDs) are safe and effective.¹ Yet persistent misconceptions about safety limit women's access to the IUD in many countries around the world.

The IUD's poor image among providers and users alike has helped perpetuate some medical practices that medical experts no longer consider necessary. Requirements for numerous follow-up pelvic examinations following IUD insertions discourage many women from using IUDs, while restrictions on who may insert them make access difficult or impossible for some women.

"The number one medical barrier to increased IUD use is a fear that IUDs carry a risk of pelvic inflammatory disease (PID)," says Dr. Roberto Rivera, FHI's corporate director for international medical affairs. This and other unjustified fears can be found in countries with very different cultural settings, he says.

"In countries where there is low prevalence of IUD use, there is fear to use it," says Dr. Rivera. "Such countries do not give themselves an opportunity to learn about IUD use and then to realize that there is not a problem. This is a vicious cycle. It's true in the United States and especially in sub-Saharan Africa." Brazil is among other countries with this problem, he says.

The so-called "first generation" of IUDs, which were often given to women at high risk for acquiring sexually transmitted diseases, left a negative image of the devices in many countries. "When IUDs were introduced in Brazil in the 1960s, selection of patients was poor, procedures for insertion

were poor and many ob/gyns were saying that IUDs caused abortion," says Dr. Aníbal Faúndes, senior associate in Brazil for the New York-based Population Council. "Then came the Dalkon Shield problems in the United States, which dampened any chance for IUDs here."

During the 1970s, epidemiologic studies in the United States linked the Dalkon Shield with PID, leading to the withdrawal of this early version of the IUD from the market and vastly reduced use of IUDs in the United States.

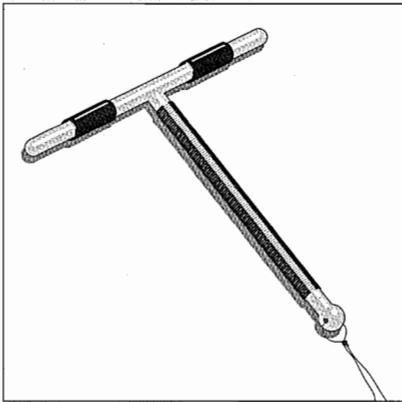
Dr. Frederick Heaton, a U.S. gynecologist in North Carolina with a busy private practice, performs very few IUD insertions, about six per year. "The IUD is a very good form of contraception, particularly for women who are between having children and for women in monogamous relationships," he says. Its poor image, however, discourages women from using the method.

A NEW GENERATION

Today's IUDs, the so-called "second generation" devices, include the Copper T 380A, also known as the TCu 380A. Research has shown conclusively that this IUD is safe if inserted by trained personnel in women not at high risk for acquiring sexually transmitted diseases. It is as effective as other reversible methods, including implants, and it works for at least eight years, making it one of the world's most cost-effective methods.

Research findings on the new generation of IUDs are clear, says Dr. Sheldon Segal of the Population Council, which co-sponsored an international conference in 1992 on scientific issues concerning the IUD.² A series of such meetings around the world is being planned to help get current scientific information into the decision-making process, and thus reduce existing barriers to use.

Some nations have long recognized the advantages of IUDs. In Indonesia, for example, IUDs are promoted by the national family planning program,



according to Dr. Sulaiman Sastrawinata of BKS PENFIN, a medical research group there. But Indonesia is the exception. Egypt is another place where IUDs are widely used.

Fear about infection carries great weight in parts of the world where childbearing is important to the status of women. Since PID can lead to infertility, pelvic infection is especially feared among childless women. In some countries that generally consider the IUD to be safe, guidelines discourage IUD use by women who do not have several living children, even if they are at low risk for acquiring sexually transmitted diseases that can lead to PID.

In a few countries, conditions for proper insertion by trained personnel may not be available, especially in rural areas. When there is a high risk of infection during insertion, it may be wise to use IUDs only among women with children, experts say, even if this is a barrier to use.

"Most clinics do not advise IUDs for nulliparous women [those who have not borne a child], although it is not an absolute contraindication," says Dr. Suporn Koetsawang of the Siriraj Family Health Research Center, a World Health Organization (WHO) collaborating center in Bangkok. In Indonesia, similar recommendations are made.

WHO CAN INSERT?

The amount and type of training required to insert IUDs varies among countries. In Egypt, only physicians are allowed to insert IUDs. In Sri Lanka, assistant medical practitioners, nurses and midwives generally are not trained for insertion, although some training for these groups has been done. In Indonesia, midwives and assistant midwives insert IUDs after completing one week of training and 12 supervised insertions.

Most countries still allow only physicians to insert, which generally means women cannot receive IUDs through mobile units or other service delivery outlets in rural areas. Even where non-physicians are allowed to insert IUDs, the training requirements can be overly restrictive.

As early as 1983, WHO reported: "In places where different categories of health workers have been used in IUD distribution programs, their professional background appears to be less important than a well-conducted practical training program."³ Many other studies have found that nurses, midwives and assisting midwives can insert IUDs as competently as and sometimes better than physicians.

"We think that someone can insert IUDs safely after performing 50 to 60 vaginal examinations and 10 to 15 correct insertions under supervision," says Dr. Joseph Kierski, medical



BERYL GOLDBERG

A SINGLE-CHILD FAMILY IN BEIJING, CHINA, WHERE ONE-CHILD FAMILIES ARE ENCOURAGED, AND IUDs ARE A WIDELY-USED METHOD OF CONTRACEPTION.

officer for WHO's Maternal and Child Health Unit.

New WHO guidelines on IUD use, expected to be available this summer, recommend a standard curriculum of approximately five days of theory and five days of practical work. "But the standard has to be adapted to the conditions of the country," says Dr. Kierski. "There is nothing rigid. It is the trainer who can decide."

JHPIEGO, the Johns Hopkins Program for International Education in Reproductive Health, has found competency-based training to be effective, especially when working with models of a woman's pelvis. In a 1991 study in Thailand, JHPIEGO compared a two-week training session using the models with a control group using a six-week training session without models. Those using models showed clinical competency after an average of only 1.6 real insertions, compared to 6.5 average insertions for the control group. "There was a more than 50 percent cost savings and a significant increase in both client and trainee satisfaction," JHPIEGO reports.⁴

FOLLOW-UP EXAMINATIONS

A growing body of research has shown that extensive examination schedules after insertion may not be necessary. During the first four to six weeks after insertion of an IUD, women are at slightly increased risk of infection. Beyond that time, however, there is no increased risk of PID for women who are in monogamous relationships. Good counseling at the time of insertion and reliance on a woman's own judgment about her symptoms and needs could reduce the need for most follow-up visits, experts have found.

Policies and practices regarding follow-up visits vary extensively around the world. Indonesian guidelines recommend visits at one week, one month, three months, six months, every six months after that, and any time a woman has complaints or side effects. National guidelines in Thailand call for visits at one month, three months and yearly thereafter.

In Sri Lanka, says the medical director of the Family Planning Association, Dr. Sriani Basnayake, "There are no national guidelines or prevailing policies regarding the frequency and number of follow-up visits. Each institution has its own follow-up schedule."

The forthcoming WHO guidelines, explains Dr. Kierski, may include a card for recipients that on one side would summarize possible symptoms and side effects, such as

irregular or excessive bleeding. The flip side of the card would suggest a schedule for follow-up visits to the clinic. "We recommend that the woman return for her first visit between four and six weeks and then again after a year. Then a woman can have an annual visit if possible."

Dr. Barbara Janowitz, an FHI economist, has studied IUD follow-up schedules in terms of cost and quality of care: "We need to let the woman decide when she needs care as much as

possible instead of depending on a rigid follow-up schedule that is usually not necessary."

Using data from FHI's multi-country clinical trials, Dr. Janowitz and her associates found that almost three of every four follow-up visits involved women who had no symptoms or only mild ones.⁵ Just 75 out of these 8,490 visits by women with mild or no symptoms (less than 1 percent) resulted in the need for medical attention.

MEDICAL ANSWERS TO QUESTIONS ABOUT IUDS

Questions

Do IUDs cause pelvic inflammatory disease (PID)?

Medical consensus

Not if inserted aseptically by properly trained medical personnel, in women who are appropriate candidates; insertion carries risk of infection but if treated properly for three weeks after insertion, any infection should not lead to PID.

Research findings

Recent major multinational studies found risk of PID among IUD users to increase only for about the first three weeks after insertion or due to the patient's previous exposure to STDs. There is no long-term relationship between IUD use and PID outside the STD risk factors.^{1,2,3}

Do IUDs cause infertility?

No, the IUD itself does not cause infertility, and return to fertility is high after IUD use. Women at high risk for STDs are at risk for PID and PID-related infertility.

Studies have found no correlation between IUD use and infertility.⁴

Is there pain or bleeding with IUDs?

There is initial cramping and irregular or heavy bleeding during the first few months after insertion, which generally decrease over time.

The newer copper-bearing IUDs generally have lower removal rates due to pain or bleeding than the older devices.^{5,6}

What are the chances of spontaneous expulsion?

Spontaneous expulsion sometimes occurs immediately after insertion or with severe cramping. Therefore, women should check their IUD strings for correct placement and return for an early follow-up visit.

Expulsion rates for the copper-bearing IUDs are consistently lower than those for inert devices.^{7,8} Newer IUDs are smaller and flexible, thus conforming better to the shape of the uterus.

Is there risk of uterine perforation during insertion?

The incidence of uterine perforation is very low if providers are trained properly.

A recent 10,000-case multinational study reported very few perforations; of those reported, no IUDs were found to pass into the abdominal cavity.⁹

Are IUDs abortifacients?

There is strong evidence that they are not. The contraceptive action of IUDs containing copper appears to occur before fertilization.

New data confirm earlier reports that copper IUDs generally incapacitate sperm before fertilization.¹⁰

—Debbie Barr

FOOTNOTES

1. Farley TMM, et al. Intrauterine devices and pelvic inflammatory disease: an international perspective. *Lancet* 1992; 339 (8796): 785-88.

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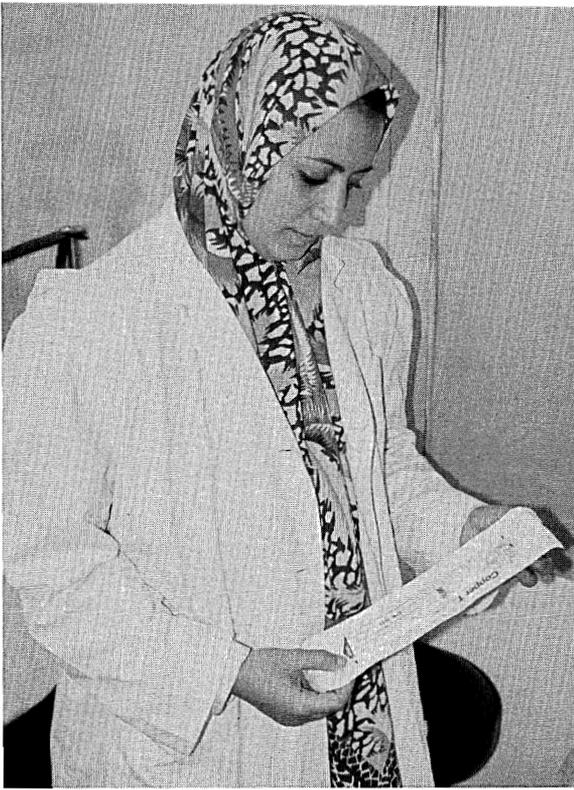
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NASH HERNDON / FHI

A DOCTOR IN CAIRO, EGYPT, PREPARES
A COPPER IUD FOR INSERTION.

"We hope that clinic policy and practice in family planning programs can shift to encourage fewer recommended follow-up visits while at the same time encouraging women who feel that they need assistance to seek medical help," says Dr. Janowitz. "This would necessitate that women be given clear guidelines about when they should return. Such a change would hopefully result in more women getting contraceptives, better and more complete advice being given to new acceptors, and better care provided to women who do have problems. By providing less unnecessary care, a better quality of care can result for more women overall."

She acknowledges that many physicians would recommend an annual clinic visit, including a Pap smear, as a good health practice for women to follow. This visit is not necessary, however, to assure safe use of IUDs, she says.

OTHER BARRIERS

There are other ways access to IUDs is discouraged. Cost can be a deterrent. In the United States, for example, private physicians charge from U.S. \$160 to U.S. \$400 to insert an IUD, making the method too expensive for many women.

Lack of marketing can make widespread use unlikely. No promotional effort to encourage IUD use is currently being undertaken in the United States. "What the IUD world needs in the United States is a product sales effort that can only be undertaken by a major

pharmaceutical company," says Dr. Segal of the Population Council. "That would take us into the other medical issues — better medical training, encouraging interest on the part of practicing physicians and on the part of potential users. These things happen when you get a real sales promotion behind a product."

Underlying all efforts to increase access to IUDs is the need to improve its image. This means getting the latest scientific information to the medical community and the right information to users.

"Image is very important," says Dr. Faúndes of Brazil. "If any of the main actresses in a soap opera in Brazil said, 'I am so happy that I have an IUD because it's been so good for me,' that would have a tremendous impact." In addition to cultivating confidence among users, more physicians would seek training, he says.

The IUD never got established in Mali, a West African country of 8.5 million people, in part because of its poor image among users and providers.

"Many rumors started about the IUDs migrating into women's stomachs and hearts or causing cancer," says Dr. Fanta Diabaté, medical director at the Hamdallaye Maternity Hospital in Bamako, the capital. Such rumors persist today, she says, which encourage providers to prescribe the pill instead.

IUDs are not often used in Thailand because of physicians' concerns about failure rates and complications, according to Dr. Suporn of Thailand. "In a small community, if any serious complications occur, the provider will lose the trust of the whole community," he says.

Image can be particularly important where unique opportunities exist to encourage IUD use, such as insertions following delivery of a child. "Because of the scarce contact between clients and providers, postpartum IUD insertion is highly recommended," reports Dr. Sulaiman in Indonesia.

Insertion is easy to accomplish immediately after expulsion of the placenta, and the IUD does not interfere with lactation. It provides a safe, effective contraceptive at one of the few times when women in many countries have ready access to birth control. FHI researchers have found that inserting the TCu 380A IUD in the immediate post-placental

period — within 10 minutes of placental delivery — is safe and is not associated with increased risk of infection, uterine perforation or prolonged postpartum bleeding.⁶

Yet few countries have medical personnel trained in immediate post-placental insertion. "Most people still think it can't be used in the immediate postpartum, that it's too risky," says Dr. Rivera of FHI, which is helping evaluate programs on postpartum insertion in Kenya, Egypt and Mali.

There are also a few useful models for encouraging access to IUDs. In Colombia, for example, PROFAMILIA matches the potential risk of infection with the benefit of protecting a woman against an unwanted pregnancy. A childless woman or a woman with a history of ectopic pregnancy, if living in an urban area, "is counseled to use another method because she has ready access to a wide variety of alternatives," says Dr. Miguel Trias, executive director of PROFAMILIA, one of the largest family planning organizations in the world. "But in rural areas, we believe the risk of infection is low enough to insert an IUD rather than have an unwanted pregnancy."

For the access of IUDs to expand significantly throughout the world, a combination of activities will be needed. Better medical training that incorporates current scientific findings will help, as will creative marketing efforts for IUDs. Both should encourage recognition that today's IUDs are safe and effective.

— William R. Finger

Debbie Barr, a doctoral candidate in pharmacology at Duke University, Durham, N.C., assisted with research for this article during an FHI internship.

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Seminars Offer Key to Better Family Planning

“Contraceptive technology updates” bring together local and international experts to change policies and practices.

Colonial laws prohibiting the use of any contraception in much of francophone Africa are gone, but left in their wake are some of the world's more restrictive regulations regarding who may provide contraception, how it can be delivered and who may use it.

These rules, together with widespread misconceptions about health risks of modern contraception, undermine family planning service delivery in the region.

But a series of meetings has begun to change this legacy. In three countries, reproductive health seminars have played a critical role in initiating changes that make it easier for women to use family planning.

At meetings in Senegal, Niger and Togo, family planning experts, program managers, providers and government officials gathered to learn the latest clinical and programmatic news in family planning. This exchange of information set the stage for easing overly restrictive guidelines in each country.

Called “contraceptive technology updates,” or simply CTUs, these meetings typically feature local, regional and international specialists who share research findings on relevant family planning issues with participants.

“Lack of scientific information among providers is one of the greatest barriers to contraceptive access in Africa,” says Pape Gaye, director of the West Africa office of the Program for International Training in Health (INTRAH), located in Lomé, Togo. “There is a tremendous unmet demand in francophone Africa, especially for current scientific information on health and contraception.”

The majority of health providers in West Africa still believe IUDs are effective for only three years, says Gaye, identifying one important gap in

knowledge. The IUDs available today are considered to be effective and safe for up to eight years.

Updating leaders of the family planning community and national policy-makers is the first step to improving access, according to FHI's Susan Palmore, who chairs a U.S. Agency for International Development (USAID) working group on improving access to contraception. Many organizations, including FHI and INTRAH, conduct such CTU meetings for physicians around the world. “FHI's experience with CTUs has shown that educating key providers and policy-makers helps create a consensus for broadening access to family planning through changes in policies and provider practices,” Palmore says.

CHANGING POLICY

In 1990, at an FHI-sponsored CTU in Senegal, family planning leaders targeted one problem — the routine use of blood testing as a prerequisite for prescription of oral contraceptives (OCs). This unnecessary practice severely limited women's access to the pill because the tests are costly and not available outside of the capital city of Dakar.

The CTU featured a study on the usefulness of laboratory tests prior to OC provision in Senegal. Study results gave clear evidence that such requirements were not needed. In light of research showing no ill effects on women's health in countries without lab test rules, the group of about 150 doctors, nurses, midwives and government officials recommended the elimination of such testing. Their recommendation was later adopted by the government as national policy.

Inspired by the Senegal seminar, Niger held a similar conference in its capital city of Niamey a year later. About 150 family planning leaders from throughout the country and nearby nations gathered for the four-day event, sponsored by USAID with technical assistance provided by the Washington-based University Research Center (URC) and FHI.



Participants, ranging from government policy-makers to nurse midwives, analyzed Niger's protocols and practices. "The CTU format gave us all the opportunity to discuss frankly the misconceptions in contraceptive technology," says Bill Emmet of Niamey, a URC official, "and to open the way for a more liberal and informed attitude by health workers toward making a variety of methods available."

The meeting's title in French, "Journées de réflexion," translated as "days of reflection," captures the essence of the CTU, which featured new scientific information and then considered ways of applying the findings to the nation's health policy.

Prior to the Niger conference, health officials in that country had identified several obstacles to widespread use of family planning: excessive screening for pill prescription, mistrust of injectable contraceptives and the absence of postpartum contraception.

Some physicians attending the conference were resistant to the idea of eliminating laboratory tests and pelvic examinations as a requirement for pill provision, says Emmet, "but it was obvious that their arguments had been considerably weakened by the testimony of acknowledged international experts."

Two years after the conference, these restrictive procedures are no longer insisted upon or even suggested. "Today, women who have had to take courage in hand in the first place are no longer subjected to the indignity of unnecessary and embarrassing procedures," says Emmet. "This meeting sent a powerful message to policy-makers."

The Niger CTU brought about two other immediate changes: licensed practical nurses, the equivalent of nurses' aides, are authorized to provide family planning services, and village health workers can dispense oral contraceptives after an initial prescription. The CTU also helped lower the age and parity criteria for injectable contraceptives.

Togolese officials, some of whom attended the Niger meeting, decided to use the CTU format to acquire new information and spearhead changes in national family planning policies. Working with FHI and INTRAH, Togolese health officials held a three-day symposium in 1992 that gathered family planning leaders from Togo and nine other African countries.

The final declaration of the Togo meeting recommended explicit policies for authorizing family planning services for adolescents and for promoting the use of non-clinic service delivery approaches, such as social marketing. Since then, the Ministry of Health and Population has endorsed the recommendations.

CTUs: A PROCESS

In the West African CTUs, information about local practices was gathered prior to the conferences to help guide the content of the program and to identify relevant research. "It is useful to have in-country data showing the potential positive impact of removal of these local barriers on contraceptive use and continuation rates, resource savings and quality of care," according to Gaye.

Presenting international data can be critical as well, he says. In Togo, such information was pivotal in convincing participants to make two recommendations: permitting a greater array of injectable contraceptives in that country and allowing distribution of pills through outlets other than clinics.

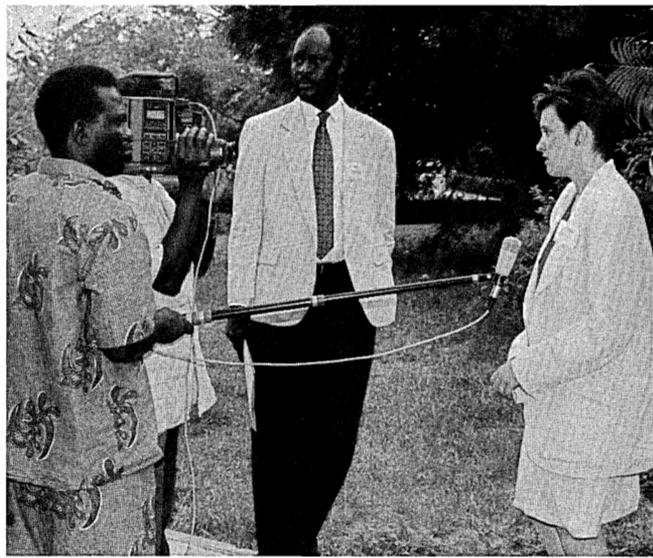
Inviting a broad sampling of the family planning community, including nurses and midwives from rural health centers, has also been central to the CTUs' success. Policy-makers learn about reality in the field from the service providers, and the providers have an opportunity to help shape policies they will later implement, says Gaye. "They [the providers] feel a sense of ownership because they've had a say in designing these policies," he says.

Yet revising policies and guidelines alone may not eliminate a medical barrier. Even though Senegal has relaxed its rules about blood testing, for example, many providers continue to require laboratory tests before prescribing pills for their patients.

A report by the U.S.-based Futures Group underscores the need to follow CTUs with training at the service delivery level. "Providers still have attitudes and biases that are deeply rooted," explains Katrina Galway, senior research scientist at The Futures Group, who interviewed providers in 17 clinics throughout Senegal.

"It's very difficult to change habits in a culture where providers are trained in health but not family planning, where their priorities are looking for contraindications, not providing access to family planning methods," says Galway, adding that this orientation is evident even in how family planning clients are described: "les malades," or "the sick."

CTUs can reach only a small percentage of a country's providers. Follow-up training helps disseminate important findings from a CTU. In Togo, for example, officials planned service provider training projects to follow the CTU. Changing service delivery practices is the next step. Research under way by INTRAH and FHI may guide future training



LYNN KRUEGER ADRIAN OF FHI IS INTERVIEWED BY A TELEVISION NEWS TEAM COVERING A 1992 CONTRACEPTIVE TECHNOLOGY SEMINAR IN LOMÉ, TOGO.

projects in how to best bring these policy changes into the clinic.

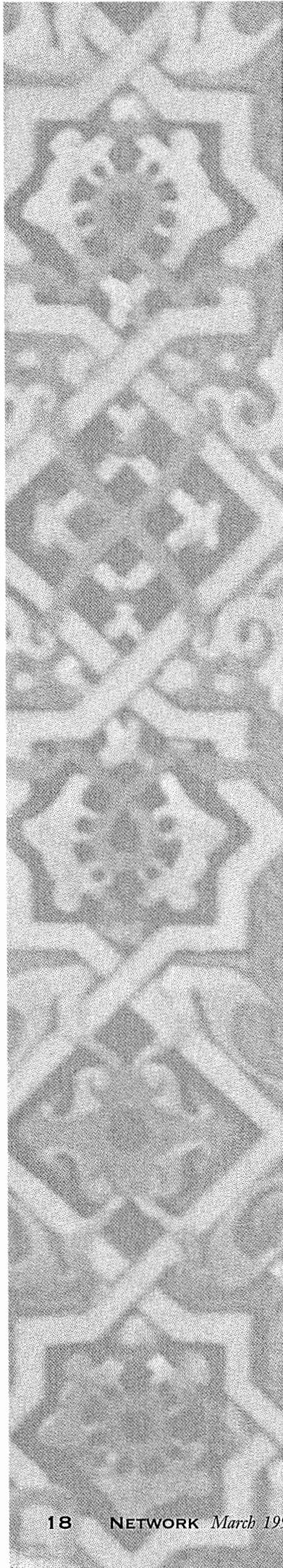
"The challenge for us now is to translate the written family planning service policies and service standards into service providers' practices," says INTRAH's Maureen Corbett. Some providers in Togo, for example, have been hesitant to follow the CTU's recommendation to give women at least six packets of pills, she says. Some providers have argued that supplying more than a single packet might discourage a woman experiencing side effects from seeking help at the clinic, simply because she still has several packets of OCs available.

An array of formidable barriers will remain, even after good changes are brought about by CTUs. Conservative prescribing practices and reluctance to promote contraception for women who have fewer than three children are still key barriers to expanding contraceptive prevalence, even in countries where CTUs have been held.

In Niger, a major consequence of the CTU was recognition that poor treatment of clients discourages people from seeking services. To address this issue, another CTU was held in 1992 to focus exclusively on the rights of the client.

"Initiatives such as the CTUs are essential to the government's efforts to sensitize its health workers to the demographic importance of family planning," says Emmet. "Once we have convinced a nation's health workers of the importance of their contribution to family planning, we can then begin to chip away at non-medical barriers associated with cultural norms and traditions."

— Sara Townsend



Next Step for Egypt - Access to More Methods

CAIRO, Egypt — On nearly any work day, groups of men huddle upon the windy roof tops of crowded commuter trains speeding into the city. Other workers cling precariously to rear bumpers or dangle from open windows from the outside of packed city buses.

In Egypt, where the population has doubled during the past 30 years to 55 million, examples of crowding are not hard to find. Even satellites in space can spot the unhappy trend, says Dr. Maher Mahran, who heads the government's National Population Council.

He displays satellite photographs at the NPC offices that portray farmland as green and urban areas as red. Taken over several years' time, the photographs show dramatically how the narrow strip of Egypt's fertile farmland along the Nile River has dwindled as the red splotches of urban growth in Cairo and elsewhere have spread unchecked.

"This population problem is like a rash upon Egypt's future," says Dr. Mahran, a former chairman of the Department of Obstetrics and Gynecology at Ain Shams University in Cairo. "This is why family planning is so vital for us. This 'rash' affects all of us — it affects every part of our economy, our agriculture, the kind of world our children will have."

The Egyptian government has promoted family planning vigorously in recent years and can point to encouraging achievements: the annual rate of population growth has declined to 2.3 percent, down from 3 percent in 1985; two of every five married women of reproductive age use contraception; and Egyptian women today are averaging just over four births during their lifetimes compared with seven births on average for women a generation ago, during the 1960s.

Even more striking, perhaps, is that the number of annual births in Egypt began declining for the

first time in 1989, and the number of births each year since then has declined compared with the preceding year.¹

"I'm not saying this is very excellent, but taking into consideration all the difficulties, it is a good achievement," Dr. Mahran says of such statistics. "Today, I can even go on television and talk freely about the need to limit ourselves to a two-child family. Given our culture, our heritage for having large families, I would not have been taken seriously about such an idea even just a few years ago."

Thousands of health providers have been trained in family planning procedures in recent years. Throughout the country, access to contraceptive services or counseling is convenient and affordable, if not free. Nearly everyone lives within 5 kilometers of a clinic that can provide contraceptive services.²

In the 1991 Egyptian Maternal and Child Health Survey, none of the women interviewed cited high cost or inaccessibility to family planning services as reasons for not using contraception, according to Dr. Carol Carpenter-Yaman, who heads the U.S. Agency for International Development's (USAID) population office in Egypt. "That alone is a remarkable achievement," she says. Since 1978, USAID has spent \$160 million in Egypt to help curtail population growth.

BETTER ACCESS, MORE METHODS

Yet if Egypt is to achieve the two-child family that Dr. Mahran promotes, additional efforts will be needed, say USAID and other family planning experts. When hundreds of family planning providers met for contraceptive symposiums last fall in three Egyptian cities, financed by USAID and sponsored by NPC and FHI, they heard about ways to attract more people to family planning simply by eliminating those medical practices or regulations that tend to discourage contraceptive use.

Expanding the variety of contraceptive meth-

ods available in Egypt would surely attract more people, experts said. Currently, only two methods are widely used. Of all Egyptian couples who use contraception, 83 percent depend upon oral contraceptives or intrauterine devices (IUDs).³

Among areas identified by experts to improve access to contraceptive use, either by changing medical practices or regulations, are the following:

Norplant — While Norplant has been approved for general use in the United States and in many other countries, Egypt continues to confine its use to a few research projects. Yet the subdermal implants, which slowly release the hormone progestin to provide five years of contraception, have been tested successfully among 55,000 women in 44 countries, including more than 4,000 Egyptian women since 1982.⁴ Norplant is an attractive alternative for women who have problems with other available methods and it may also be more appealing than IUDs or the pill for many Egyptian women. Clinical trials have demonstrated that Norplant is culturally acceptable among Egyptian women.

Progestin-only pills — Also unapproved for general use in Egypt is the progestin-only oral contraceptive pill, sometimes called the "minipill" or POC. This pill tends to have a lower incidence of such undesirable side effects as nausea, headaches and high blood pressure — problems that might discourage some women from using other oral contraceptives.

Unlike other oral contraceptives, which contain estrogen, POCs can be used by women who have contraindications to estrogen — those with circulatory problems, for example. POCs are also considered a preferable contraceptive for breastfeeding women than other pills, since POCs do not affect lactation.

Oral contraceptives — Other oral contraceptives, those that contain estrogen, are readily available and affordable in Egyptian pharmacies without prescription. Older formulations of the pill, however, are just as easy to get and are significantly cheaper than newer low-dose versions.

These older formulations use high doses of estrogen and tend to have more undesirable side effects. Some women attracted to a better price probably discontinue the pill simply because of side effects — problems they would not have suffered with newer low-dose formulations. Pricing all pills the same or removing the high-dose versions from use would resolve the problem.

Voluntary sterilization — Tubal ligation is available in Egypt for health reasons, but generally is difficult for a woman to obtain. Religious and cultural values discourage irreversible surgical forms of contraception. A

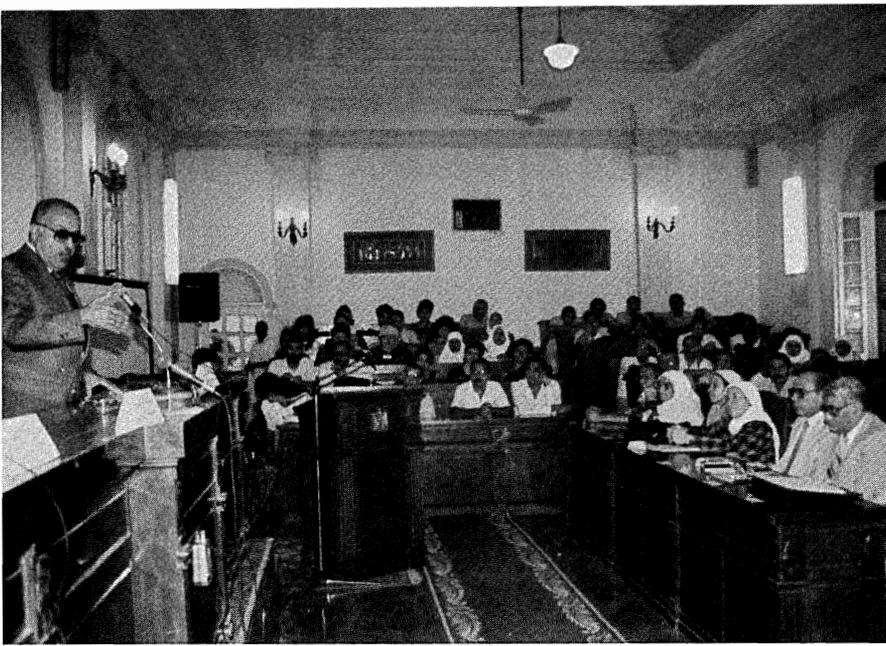


NASH HERNDON / FHI

doctor must certify that a woman has unusual medical needs that require sterilization in lieu of other available methods, and its use is often confined to older women who already have several children. Male sterilization, or vasectomy, is almost never performed. In Egypt, the burden of family planning is widely viewed as the sole responsibility of women.

Injectables — Only physicians specializing in obstetrics and gynecology are authorized to give contraceptive injections in Egypt. Because the injections are often given in the buttocks and physicians are usually men, some women are probably discouraged from using

ALL THE PHYSICIANS AND NURSES ARE WOMEN AT A CLINICAL SERVICES IMPROVEMENT CLINIC IN EL MINYA, EGYPT.



NATIONAL POPULATION COUNCIL, EGYPT

DR. MAHER MAHRAN, HEAD OF EGYPT'S NATIONAL POPULATION COUNCIL, ADDRESSES PHYSICIANS, NURSES AND OTHER HEALTH PROVIDERS DURING AN OCTOBER 1992 SEMINAR IN EL MINYA, EGYPT.

injectable contraceptives because of modesty. Allowing nurses to give injections and to provide other routine procedures, including counseling, would encourage contraceptive use, as would giving injections in the arm for contraceptive drugs that can be administered in that way.

Unnecessary contraindications — As in many countries, outdated or unwarranted contraindications are sometimes used in Egypt to deny women IUDs or oral contraceptives. Women with varicose veins or with diabetes, for example, have been advised not to use the pill, even though neither condition is considered a clear contraindication. Some women who simply report having headaches are warned not to use the pill.

Unnecessary examinations — While examinations are important, some physicians may require so many that women turn away from using contraception. Some physicians, for example, may require five or six pelvic exams during the first year alone for an IUD recipient, which discourages some potential users.

A WOMAN'S TOUCH

On a recent day in El Minya, a city on the Nile in central Egypt, a 23-year-old mother of two was among clients being served at a small but well-equipped family planning clinic. Nestled among the neighborhood markets and small shops of a bustling street lined with tall

trees, the Clinical Services Improvement Program clinic is noteworthy for a feature that all CSI offices share — women doctors are available.

Sediaa, the mother of two, tells the staff that she came to CSI because of its reputation for having good facilities and because she will be treated there by a woman. She was married at the age of 17, a staff member says, and has depended upon the pill in recent years to keep from having more children. Because she does not like some of the pill's side effects, she came to the clinic that day to have an IUD inserted.

"Our prices are low — higher than the token fee a woman might pay at a government clinic, perhaps, yet much lower than what Sediaa would pay to visit a private physician," Ezzat Salah El Din, local CSI administrator and the clinic's only male employee, says in Arabic through a translator. "A very important thing for this lady and for so many others we serve is that they feel more comfortable when they are served by women. All three of our physicians are women, as are all our nurses."

An IUD insertion, including laboratory tests and a physical examination, costs about U.S. \$1 at government clinics compared with about U.S. \$3.50 at a CSI clinic. Private physicians, however, typically would charge between U.S. \$30 and U.S. \$60 for that service.

Started in 1988 with clinics in six Egyptian cities, CSI today operates more than 100 centers and satellite offices. Initiated by USAID and the Egyptian Family Planning Association, the project receives some operating funds from the government's Ministry of Social Affairs while using modest client fees to help

underwrite equipment and services.

Because Egypt has a relatively high number of physicians, even routine family planning functions are often reserved for physicians, who are often men. Especially in small rural clinics, nurses would rarely be used even for counseling, says Dr. Moshira El Shaffie, director for an Egyptian Ministry of Health family planning project that receives USAID support.

Using nurses to give contraceptive injections and to perform certain other routine procedures, such as counseling, would encourage modest women to use family planning, she says. In Egypt, where many women cover their hair in public out of a sense of modesty, such considerations are important.

"If we are going to move forward and educate clients better, we must use our nurses for counseling," Dr. Moshira says. "Partly because so many nurses are women, partly because most of them also happen to live in the same village or neighborhood as their clients, and perhaps even more important, because they really speak the everyday language of the clients — for all these reasons, nurses can certainly help us to be more effective."

In the past three years, she says, 8,000 nurses have been trained in family planning procedures in Egypt. There are currently more than 3,000 clinics where family planning services are available. While that level of expansion has been an important accomplishment, the time has come, she says, to improve the quality of service and training.

"We have indeed expanded rapidly. Now those 8,000 nurses should be trained again, in counseling and with emphasis on improving the overall quality of family planning," Dr. Moshira says. "Good family planning services in Egypt must fly like a bird — the doctors are one wing, but the nurses are the other. We must not ignore that second wing of the bird, if we are to see it fly."

THE EVOLUTION OF ACCESS

While it may be true that contraceptive services can be expanded, many physicians defend the status quo as a necessary step in an evolution toward better family planning. Among them is Dr. Ezzeldin O. Hassan, who cautions that family planning services should be modified gradually and with great care.

When IUDs were first allowed in Egypt, only specialists in gynecology were allowed to insert them, says Dr. Ezzeldin, director of the Egyptian Fertility Care Society and chairman of obstetrics and gynecology at Mansoura University. "We have since then gradually relaxed our guidelines to allow general practitioners to perform that procedure," he says.

"There are always medical barriers to service in the beginning, and it is only prudent

that there should be," he says. "I can assure you if we had begun our IUD program without that limitation in the beginning, the entire IUD program would have soon collapsed in Egypt."

He notes that access to oral contraceptives in Egypt is much easier than in the United States, where a prescription is necessary. As for high-dose pills being readily available, Dr. Ezzeldin and several other Egyptian physicians believe that this formulation is more effective than low-dose pills for heavy-weight women. "A good percentage of our women in Egypt are obese," he says.

While careful scientific analysis of the weight issue is apparently yet to be done, other experts noted that the pill's steroids would take longer to metabolize in heavy-set women, which means longer retention of the pill's active ingredients and thus suggests a stronger dose is not needed for heavier women.⁵

In any case, more women would probably continue using oral contraceptives if they were not attracted to high-dose pills simply because they are cheaper. By increasing the price of high-dose pills to the same as low-dose formulations, the problem could be eliminated while keeping high-dose pills readily available for women who may need them.

As for better access to female sterilization, Dr. Ezzeldin is among physicians interviewed who believe the medical community of any country must operate under the constraints of a nation's cultural and religious framework. "There are indeed barriers in this country for abortion and for sterilization. But these barriers are not medical ones," he says.

His views should not be misunderstood, Dr. Ezzeldin cautions, as an endorsement of keeping the status quo permanently. Achieving better access to family planning, he says, is vitally important. "We have reached a certain prevalence rate of contraception in Egypt, and that is good. Yet if we do not look for ways to make meaningful improvements in our services, the increase in contraceptive prevalence in the coming years will be very small," he says.

Better counseling for clients and training of health providers, he believes, are ways to expand the use of family planning.

At Al-Azhar University in Cairo, Dr. Nabil Younis agrees that cultural factors play an important role in shaping a nation's family planning policy. For that very reason, he favors the approval of Norplant for general use.

"Norplant is important to us because it

can become a replacement for sterilization, which is not accepted by so many for cultural or religious reasons," says Dr. Younis. Among 240 women who have received Norplant in research projects at his university, very few have become dissatisfied enough to seek its early removal, says Dr. Younis, a professor of obstetrics and gynecology.

"Prevalence rates clearly show more and more women are using contraception every single day here in Egypt," he says. New options like Norplant can only help. "We now have something greater than 40 percent of women between 15 and 49 using contraception, and the best that anyone can expect is probably 70 percent. I believe Egypt must and will continue to move toward that goal of 70 percent."

—Nash Herndon

FOOTNOTES

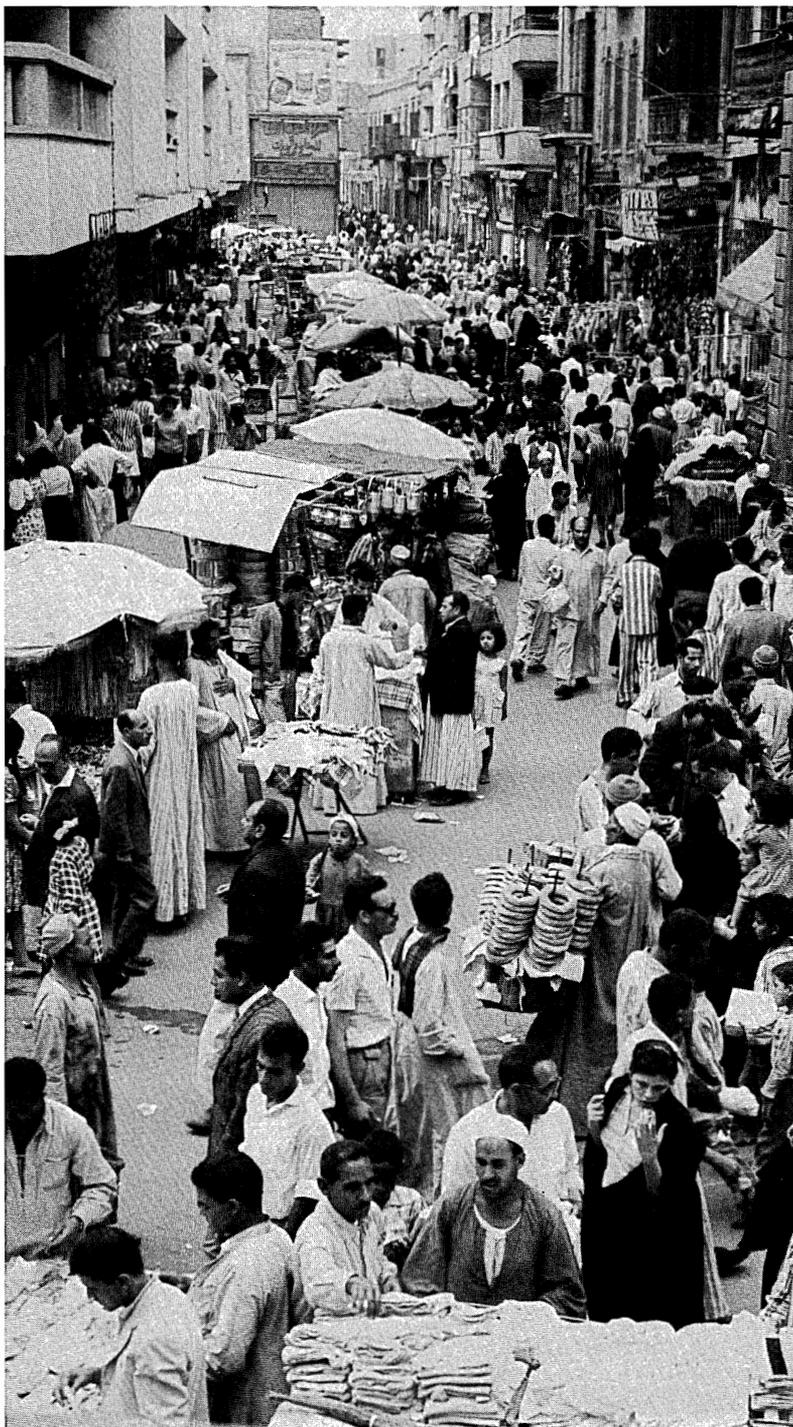
1. The Futures Group. *Strengthening Egypt's Population Program*. 1992; Central Agency for Public Mobilization and Statistics (CAPMAS). *1991 Egyptian Maternal and Child Health Survey*. 1992; Gillespie D, Carrino C, Johnson C, et al. *Egypt Population Assessment: A Report for USAID/Cairo*. 1989; NPC statistics.

2. Egyptian Ministry of Health statistics.

3. Hassan EO, Kafafi L, El Hussein M, et al. The acceptability of Norplant in Egypt. *Adv Contracept* 1992; 8 (4): 331-48.

4. Ibid.

5. A widely-used reference suggests using high-dose pills when a woman experiences "contraceptive failure" while using low-dose pills correctly, although it says reducing the number of pill-free days during the low-dose pill cycle, from seven days to five or six, is preferable. See Hatcher RA, Stewart F, Trussell J, et al. *Contraceptive Technology 1990-1992*. New York: Irvington Publishers, Inc. 1990: 256.



PEOPLE GATHER AT A CROWDED EGYPTIAN MARKET.

P. ALMASY / WHO



Dwindling Family Planning Funds Challenge Jamaica

MONTEGO BAY, Jamaica — Underlying a recent gathering here of 50 private physicians was an issue that promises to affect health providers throughout Jamaica: the 25-year-old national family planning program faces a phase-out in funding by major international donors.

To continue meeting the reproductive health needs of Jamaican families and to slow population growth, the government will be required to absorb many costs, develop cost-recovery systems and find creative ways to shift some of the burden for care to private physicians, such as those who attended the September meeting of the Western Medical Association of Jamaica (WMAJ).

Engaging private sector physicians may prove a difficult process: as a group they have little training in reproductive medicine. In addition, family planning consultations are typically not as lucrative as other types of care. Yet involving the private sector is one way to prevent erosion of some of the real gains this Caribbean island nation has made in slowing population growth and improving maternal and infant health.

The 1989 Contraceptive Prevalence Survey, conducted by Ministry of Health staff in conjunction with the U.S. Centers for Disease Control (CDC), shows that more than half of married women of reproductive age in Jamaica use a family planning method. The average Jamaican family size — 2.9 children — is low, compared with many developing countries. The success of the national family planning program in achieving this level of contraceptive prevalence has in large part spurred the planned phase-out in funding from the U.S. Agency for International Development (USAID) and the United Nations Population Fund (UNFPA).

“The major challenges facing the Jamaican family planning program are to make the program

less dependent on outside support, which means increasing the role of the private sector, improving cost recovery and increasing the availability of long-term methods through training programs,” says Dr. Nancy Williamson, director of FHI’s Division of Program Evaluation.

The government’s immediate strategy is to encourage users to shift from short-term to more long-term and permanent contraceptive methods. In 1989, only 16 percent of women using modern methods were using long-lasting methods (female sterilization and IUDs), and of the female sterilizations performed, 88 percent were performed by public sector physicians.

With an eye to the long term, the government is also working through professional associations such as the WMAJ to encourage private sector physicians — who now provide less than one-quarter of all family planning services — to take on more responsibility in this area.

Many general practitioners, especially physicians in the private sector, do not have adequate training in reproductive health or contraceptive technology and tend to question the safety of specific family planning methods, says Beryl Chevannes, executive director of the National Family Planning Board (NFPB). Increasing access to family planning in Jamaica, she says, will require a change in both providers’ attitudes and skills.

“While physicians endorse the concept of family planning, they have reservations about some methods... [specifically] the injectable and the intrauterine device,” says Dr. O.P. McDonald, medical director of the National Family Planning Board.

Medical professionals at the WMAJ meeting who attended a presentation on hormonal contraception given by Dr. Allan Rosenfield, dean of Columbia University’s School of Public Health, showed keen interest in current information on the safety of IUDs, and the various hormonal methods currently available. Participants showed particular

interest in Norplant and Depo Provera, both of which have been approved for use in the United States in the past two years.

"The private physicians with whom I spoke are very interested in working to improve family planning options for their clients," says Dr. Rosenfield. "What they need, to accomplish this, is better access to current information on contraceptive technology and related medical questions, such as appropriate screening criteria and contraindications for use of the various methods available. They were most interested in the discussion on medical barriers to use, and on quality of care."

"Few physicians know how to handle bleeding problems associated with Depo [Provera] use, and need updated information," adds Chevannes, who participated in the meeting. "Similarly, women and doctors associate IUDs with vaginal discharge, and many doctors are not up-to-date on how to handle IUDs in cases of women with cervical erosion. Many doctors are also concerned about the problem of pelvic inflammatory disease."

Only 2 percent of married women of reproductive age in Jamaica depend upon IUDs for contraception, compared with 8 percent for injectables (Depo Provera), 9 percent for condoms, 15 percent for female sterilization and 20 percent for oral contraceptives.

As the government wrestles with ways to cope with the imminent loss of foreign donor funds, such as involving private physicians more actively in family planning service delivery, it will also confront the thorny question of remuneration for services.

"Currently, there is little financial incentive for general practitioners in Jamaica to provide family planning services," says Maureen E. Clyde, senior policy research specialist at The Futures Group in Washington, D.C. Clyde cites a 1991 survey of private physicians who reported they believe counseling patients on family planning demands too much of their time. A thorough counseling session, which should require about 45 minutes, is typically done by general practitioners in 10 or 15 minutes, about the same time as a curative care visit. The amount of time devoted to counseling by both public and private providers is very often inadequate, and it is commonly believed that this results in high contraceptive discontinuation rates.

Clyde cites another 1991 survey, this one of public sector users of family planning services, that underscores the value of counseling as a way of motivating women to use contraception. The survey concludes, however, that "it is hardly conceivable that the private doctor, with his high fees, will be able to do this, since the medical value attached to the service is perceived [among clients] as negligible."

With such financial and resource issues in mind, the Ministry of Health and the National Family Planning Board have started a pilot project on voluntary surgical contraception (VSC) to train non-nursing staff, instead of physicians, to do counseling on sterilization. The new project, carried out at Victoria Jubilee Hospital in Kingston with support from the New York-based Association for Voluntary Surgical Contraception (AVSC), has trained non-nurse personnel to counsel prospective tubal ligation clients.

Female sterilization clients have increased from approximately 50 to 100 women

a month at Victoria Jubilee, says Chevannes. Through the Ministry of Health and working with AVSC, the NFPB hopes to expand minilaparotomy services at other major hospitals and expand the use of non-nurses as family planning counselors at other sites. It also plans to encourage private physicians to refer potential female sterilization clients to centers such as the Victoria Jubilee Hospital.

—Lynn Krueger Adrian and Elizabeth T. Robinson

Ms. Adrian, who attended the September meeting of the Western Medical Association of Jamaica, is an FHI program officer.

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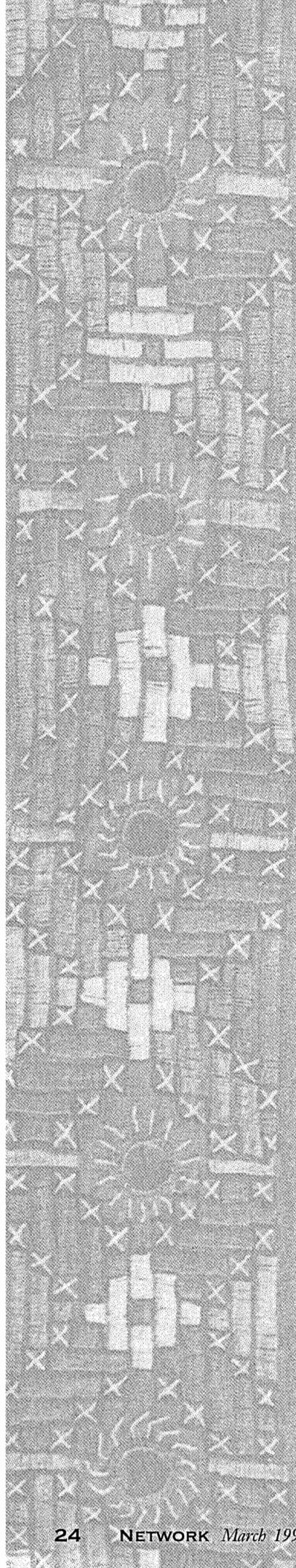
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Pakistan's Low Contraceptive Use Tied to Medical Issues

TAKHT BHAI, Pakistan — Despite government statements endorsing family planning for the last 30 years, only 14 percent of married women of child-bearing age use contraception in Pakistan. This is in sharp contrast to rates in neighboring India (49 percent) and Bangladesh (40 percent), which was formerly part of Pakistan and is also a predominantly Muslim country.¹

What has kept more Pakistanis from using contraception, and hence, from slowing one of the world's fast-growing populations?

Recent studies and Pakistani experts point to cultural factors, the large proportion of the population living in rural areas and women's lack of independence and mobility as important factors. These experts also identify two medical issues related to contraceptive access and use: what providers know about various methods and who provides family planning.

ACCESS TO IUDS AND THE PILL

On a rainy August afternoon, Khurshid Abbasi sits in the consultation room of a new family welfare center, where she works as a "lady health visitor" in northwestern Pakistan, near the Afghanistan border. The morning rush of clients has ended, and the downpour keeps the afternoon clients away for now. From this center, expanded from its former smaller quarters, a mobile unit travels into very rural areas.

"We try our best to motivate the women," says Abbasi, a warm, reassuring woman in her mid-40s. Asked how the women decide what family planning method to use, she replies, "We try to inform them about the best method to use, but they can sometimes get disturbed if they don't choose for themselves."

The center usually has oral contraceptives, injectables, condoms, spermicidal foam and intra-

uterine devices (IUDs) available. Those wanting sterilization are referred to a hospital in the nearby city of Mardan.

The choice of available methods at the clean, well-run Takht Bhai center is based on the knowledge and training of Abbasi and the other staff, not on national guidelines or regulations. This flexible approach avoids having a rigid system of guidelines dictate management decisions at each center. But it also allows standards to vary, perhaps significantly, from region to region, even center to center, depending on the knowledge and perceptions of individual providers.

As Abbasi talks, the rain beating against the roof, the importance of her judgments about methods becomes clear. Today, Abbasi has no oral contraceptives on hand. Women either have to purchase their pill packet at the market, go without protection or switch methods. Consequently, she probably will not encourage use of the pill this day.

Nor will many women be encouraged to consider the IUD. While there is no national policy on the matter, the center provides IUDs only to women who have at least two children, one of whom must be a son, says Abbasi. The restriction stems from the belief that IUDs can lead to infections and sterility. Even when providers care deeply about providing the best family planning services, unscientific beliefs may prevent them from offering better alternatives. Because there is also a high rate of infant mortality in this region of Pakistan, Abbasi and others are cautious about recommending IUDs.

The clinic's guidelines reflect a lack of knowledge about mainstream scientific findings regarding IUDs. Clear and consistent evidence shows that women face no significant increase in risk of infection from using the latest generation of IUDs, especially those containing copper that are inserted under aseptic conditions. This is true if the IUD is given to appropriate candidates who are monitored in the first six weeks after insertion. Also, IUDs are

effective and relatively inexpensive, compared to other methods.

The prevalence rates for IUDs and pills are much lower in this country of 122 million than in India, Bangladesh and other countries with religious, cultural, or geographical similarities. The most popular modern methods in Pakistan are female sterilization (4 percent of married couples of reproductive age) and condoms (3 percent). Then come IUDs (1.5 percent) followed by the pill and injectables (1 percent each). About 4 percent use traditional methods, such as periodic abstinence and withdrawal.

Even if Abbasi were well versed in the current scientific findings about IUDs and had implemented a careful monitoring system for new insertions, she would be working against Pakistan's prevailing medical opinion by promoting IUD use at her center. The Medical Council of Pakistan encourages only those trained at medical institutions to insert IUDs, or even to give injections, says Dr. Zahiur-ud-Din Khan, director general of the National Research Institute for Reproductive Physiology.

The practices of this center may also tend to discourage widespread use of oral contraceptives. The center routinely provides only one month's supply of pills and then will sell as many additional cycles as clients wish to buy. This requires that the center have a supply of pills and that clients can afford additional pills.

The tests required at the clinic may also limit use. Before receiving oral contraceptives, a woman must have a pelvic exam, which is a good general health practice but is not consid-

ered to be necessary for using the pill. Also required are urine, blood pressure and jaundice tests. Requiring these tests may have contributed to the low rate of pill use in Pakistan (1 percent). In contrast, the rate is 14 percent in Bangladesh.

Sterilization and condoms, the two methods with the greatest use in Pakistan, ironically have low rates in many developing countries. Sterilization in Pakistan is sought primarily by women over age 35 with many children and hence is not slowing the country's birth rate substantially. Condom use in Pakistan has increased in recent years after a social marketing program was established and hundreds of millions of condoms were provided by international donors.

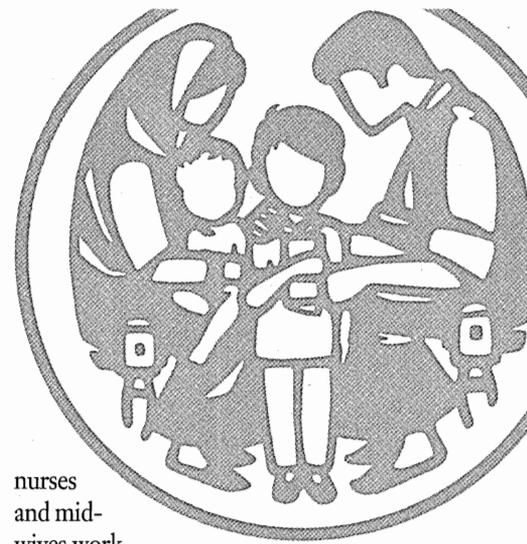
LACK OF TRAINING

Doctors, nurses and midwives have little knowledge of family planning, explain veterans of family planning programs in Pakistan. "Doctors know less about family planning than do family planning workers," says Kareem Iqbal, who recently interviewed doctors in Karachi, Pakistan's cosmopolitan port city of 7 million. A former secretary for the Pakistan Ministry of Population Welfare, Iqbal is now honorary adviser to the national Nongovernmental Organizations' Coordinating Council for Population Welfare.

"I found one extreme case where a doctor mentioned castration as a method of family planning," he says. "Sometimes if a woman goes to a private doctor for treatment for some ailment, the doctor will advise her to discontinue family planning and then come back for treatment, as if the family planning method were a cause for her ailment."

Imtiaz Kamal, a Pakistani nurse and representative in Pakistan for Pathfinder International, reports similar findings from focus groups among Karachi doctors. "When women ask general practitioners in Pakistan about family planning, the doctors make up their answers because they don't know anything about it," she says. "But they very much want to know."

Kamal has worked in family planning throughout the world for 37 years. Recently, she guided a study among



nurses and midwives working at the Pakistan Institute of Medical Science, one of the country's major medical training centers. The study found that nurses are not aware of the side effects of various methods nor do they have adequate knowledge of where to refer clients for family planning.²

"Their knowledge of family planning is almost non-existent," says Kamal. The study found that only half had received basic training in family planning, and less than one-third knew the correct meaning of family planning. Asked to name two temporary methods of family planning, 7 percent of the nurses mentioned tubal ligation, or female sterilization, which is considered a permanent method.

The Ministry of Population Welfare oversees the delivery of family planning services through some 1,300 family welfare centers nationwide, such as the Takht Bhai clinic. The centers are typically directed by "family welfare workers," who generally receive 18 months of training in family planning. Some get additional training in counseling and supervising, as Abbasi has done.

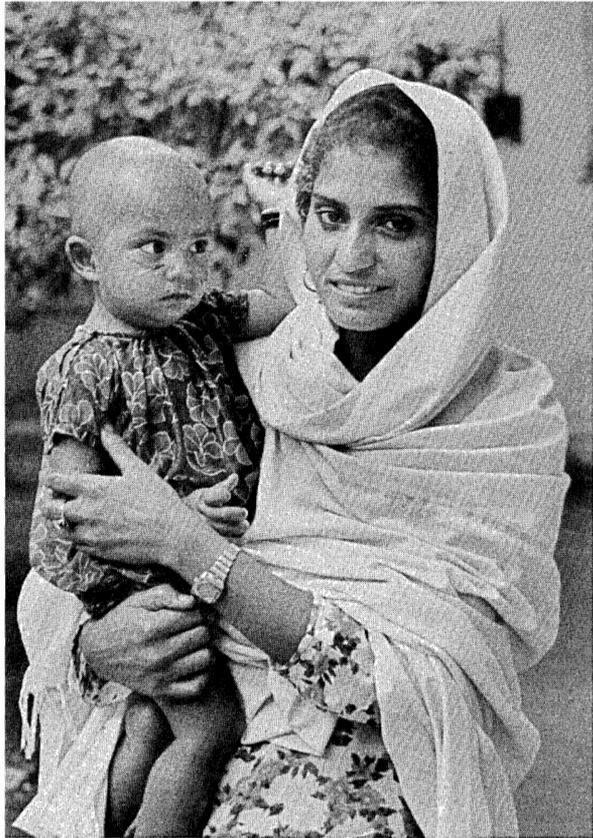
Government family planning outlets, combined with those operated by nongovernmental organizations, provide effective coverage for only 15 percent to 20 percent of Pakistan's population. In extremely rural sites, fewer than 5 percent of the population has easy access to family planning services.³ Few doctors want to go to rural areas.

In contrast, the Ministry of Health administers some 7,000 medical clinics nationwide, more than five times the number of family planning outlets. Providers in these medical clinics receive 24 months of training but nothing in family planning. Most doctors in the health departments know little of gynecology or surgical contraception, except for those who get extra training in the family welfare system.

DR. KAREN HARDEE / FHI



KHURSHID ABASSI IS A LADY HEALTH VISITOR AT THE TAKHT BHAI FAMILY WELFARE CENTER.



DR. KAREN HARDEE / FHI

AN INTERVIEWER AT THE TAKHT BHAI
FAMILY WELFARE CENTER.

Adding family planning services to the medical clinics would increase access to contraception tremendously, but first the medical staff would have to be trained to deliver these services. Seven years ago, the National Economic Council decided that doctors in all medical outlets should be trained in surgical contraception and that all paramedics should be trained in related counseling. But this plan has not been implemented.

More recently, the two ministries have been required to train the medical staff to deliver family planning services out of the medical outlets. As of now, however, obstacles to proceeding with this mandate have not been resolved, pending a decision on which agency should provide supplies, planning and monitoring.

About one-third of the 32,000 doctors in Pakistan work with the government's medical clinic system. The other two-thirds are private physicians. Private doctors provide about 60 percent of the health care nationwide, mostly in urban areas. Proposals to train private physicians in family planning have also been made, but as with the plans for government doctors, these have not been implemented.

CHALLENGES AHEAD

Pakistani experts point out that all issues regarding family planning must be examined within a broad context of deteriorating health conditions, poverty and lack of education and knowledge of family planning among users.

Hospitals and clinics are becoming more crowded, creating more chances for spreading infections, says Dr. Khan of the National Research Institute for Reproductive Physiology.

Khalida Manzoor, senior fellow at the Pakistan National Institute of Population Studies, examined how such conditions affect family planning. She conducted focus groups with 260 men and women in three Pakistani regions, who complained about a lack of sterile conditions and adequate follow-up of treatment. Women complained about heavy bleeding with IUDs, which in some cases appeared to be due to giving women the wrong size IUD, poor insertion techniques and lack of follow-up.

Manzoor also found that service providers do not have the technical information or resources to deal with side effects. Even if they do know all the information about methods, including side effects, they do not necessarily tell their clients. Women do not know, for example, that contraceptive methods are not 100 percent effective. Dissatisfied users pass the word to others, including their husbands, that family planning is harmful. Husbands are then less likely to let their wives use family planning.

"Men and women think family planning has health hazards and they worry that they can't afford the treatment and will not be able to work," says Manzoor. "This fear is stronger than the religious proscription against the use of family planning."

Findings of the recent national demographic and health survey were similar, with slightly more emphasis on religion. Of those women who do not intend to use contraception in the future, about 10 percent lacked knowledge of contraception and 13 percent gave religion as a barrier. More than two of every five said they wanted to get pregnant.⁴

Given the current level of knowledge and training about contraceptives in Pakistan, among providers and potential consumers, the best existing reference book is "Family Planning Handbook for Field Workers." Written by Imtiaz Kamal, it has been reprinted several times by Pathfinder International in English,

Urdu and Pushtu — three of the six major languages used in Pakistan — and in Arabic. This guide is designed for field workers with little background in health and family planning. The English version is 114 pages with many helpful, easy-to-understand tables on side effects and other crucial issues.

"This is the only book of its kind ever made available to the grassroots level family planning service provider both for self-teaching and for reference," says Dr. Azra Mubarak, director of clinical training for the Ministry of Population Welfare.

Such resources offer great hope in expanding the awareness and knowledge of contraceptive methods. In the end, though, significant progress will take a sustained national effort toward expanded access to family planning, through many means. These include expanding educational opportunities for medical personnel in family planning, providing clear guidelines for eligibility criteria at local clinics and showing the willingness to provide adequate support for such dedicated providers as Khurshid Abbasi.

— Dr. Karen Hardee

Dr. Hardee, a social demographer, is a senior research associate at FHI.

FOOTNOTES

1. *Pakistan Demographic and Health Survey 1990/1991*. Islamabad: National Institute of Population Studies, and Columbia, MD: IRD/Macro International Inc., 1992: 62; *1992 World Population Data Sheet*. Washington: Population Reference Bureau, Inc., 1992; Mitra SN, Lerman C, Islam S. *Bangladesh Contraceptive Prevalence Survey 1991*. Dhaka: Mitra and Associates, 1992: 13.

2. Student Teachers Class 1989-90. A study to determine the knowledge of PIMS nurses and midwives about contraception and understanding of their role in promotion of family planning. College of Nursing, Pakistan Institute of Medical Sciences, Islamabad, March 1990, unpublished.

3. Rukanuddin AR, Hardee-Cleaveland K. Can family planning succeed in Pakistan? *Int Fam Plann Perspect* 1992; 18 (3): 111.

4. *Pakistan Demographic and Health Survey 1990/1991*: 81.

Recasting Image of Contraceptives

Medical and technical messages can be simplified for ease of users.

Sex, sensuality and peer acceptance are used to sell everything from toothpaste to automobiles. Contraceptives are directly related to sex, yet they are generally presented in only a sterile, clinical way.

Products such as cigarettes and alcohol have been shown to pose significant health hazards. Even so, glamorous images of bathing beauties and rugged cowboys sell these products, with health warnings barely visible if included at all.

In contrast, family planning programs actually improve the health of mothers and babies. But promotion of contraceptives is often technical and intimidating, focusing more on risks than benefits.

Historically, most family planning products and services have reached families through a medically oriented delivery system — maternal and child health clinics, family planning clinics, hospitals and private physicians. Hence, contraceptives have been associated with illness or at least with seeking help.

Radio, television and billboards carry images of all types of consumer products to virtually every part of the world. Contraceptives must compete in this market, as providers of goods and services vie for a consumer's attention.

THE RIGHT METHOD

The most obvious aspect of contraceptive image is how a person views a particular method. Negative and inaccurate information may cause people to mistrust a method, even though they recognize the importance of a well-spaced family.

Information that is too technical and too elaborate may confuse or frighten potential users. Reading contraceptive package inserts, particularly for pills, can require a high school education.

Informing a user of all possible side effects of a method is important for that person to make good choices, yet poorly presented information can result in an unduly negative image. For example, posters often have long lists of disadvantages and warnings, with a short list of advantages. They are often displayed in waiting rooms where the client may read them without the benefit of clarifications.

Visual presentations of condoms in several countries have recently shown the impact of a positive image. A social marketing campaign in Indonesia created an association of the Dualima condom with responsible fatherhood, whereas condoms typically had been associated with illicit sex in that country.

In Colombia, a marketing project supported by Population Communication Services of Johns Hopkins University associated a condom with male responsibility. A campaign in Thailand sometimes referred to as "The Cheerful Revolution" has helped make "condom" an everyday word and has increased its acceptability. In the United States, advertisements now portray condoms as giving the user "control," particularly in relation to AIDS.

All too often, family planning products are released without a clear marketing strategy, and hence, without adequate attention to consumers' perceived needs. A thorough plan would identify unique attributes of a contraceptive method to consumers and distinguish this product from others, creating a market niche.

Researchers are developing ways to use sur-



A TURKISH FAMILY
PLANNING POSTER
ADVERTISES WITH THE
IMAGE OF A POPULAR
ACTRESS.

S EVGİLİ ANNELER BABALAR AİLEMİZE ÇOCUKLARIMIZA MUTLU BİR GELECEK SAĞLAMAK BİZLERİN ELİNDE

■ Artık çocuk istemiyorsanız. ■ Henüz çocuk istemiyorsanız
En yakın sağlık kuruluşuna hemen başvurun.

veya data to test which attributes of methods appeal most to potential users. In Egypt, for example, a survey of 2,000 men and women showed that ease of use, healthiness and effectiveness were the most important attributes of contraceptives and that the IUDs were perceived to rate higher on these attributes than did other methods. The IUD was also the most preferred method in Egypt.¹

Marketing plans could be used to counter incorrect and alarming information. Too often, such negative publicity dictates the image of contraceptives. Using technical medical

jargon to respond to false rumors can actually contribute to a negative image. Counter messages, of course, need to be accurate.

PEOPLE IMAGES

Images of those using contraception also affect how potential users will choose among various options. Generally, existing users are often viewed positively.

In a recent study in Cameroon, for example, young people thought family planning users were "intelligent, educated and affluent."² In addition, older women appeared envious of women who used contraception and

were wistful that services had not been more available during their child-bearing years.

A study in rural areas of the Philippines found that people perceived women who used contraceptives as having gained confidence and acquired greater control over their lives. Male contraceptive users saw themselves as loving, caring and considerate husbands who respect their wives. The same study, however, found that some non-users regarded family planning users as materialistic and not loving children.³

This study suggests the potential of using positive images. Images of "loving husbands" or "women with more confidence and greater control over their lives" can be used to counter negative views involving materialism. Using contraceptives may mean that a family can provide better education to their children, because there are fewer of them, and a more fulfilling life instead of one that is simply more materialistic.

Another important image that affects contraceptive use is how people view providers. Mass media can be used to improve providers' public

image. In Turkey, for example, a midwife was a heroine on a television show. In Egypt, research findings in 1988 indicated that public clinics were poorly regarded, compared to private clinics. Consequently, a non-governmental organization designed the Clinic Service Improvement program to operate clinics with higher standards. Its mass media efforts presented CSI clinics as places to get high-quality health care at an affordable price. This led to increased clinic attendance and to other public clinics aspiring to higher standards and a more positive image.⁴

Research in Ghana showed that clients perceive doctors — compared with nurses, midwives and pharmacists — as most likely to be caring, understanding, trustworthy and helpful. Since doctors have a positive image, the task in Ghana is

to enhance the image of other providers after they have been trained. In a "Together We Care" campaign that followed the research, providers pledged in parades and public ceremonies to provide better services, which improved their image. In the process, the quality of care also improved.

Even if not directly involved with family planning programs, political and cultural leaders can greatly influence the climate in which family planning will be seen. If prominent persons publicly support family planning, the image they create can help remove barriers that deter use. In the Ghana "Together We Care" campaign, for example, religious and community leaders participated in the public ceremonies at which the health-care providers swore on the Bible and Koran.

Support of family planning by religious leaders can be particularly important. In Egypt, this was the case when the high-ranking Grand Mufti made his first appearance on video to explain the Islamic religious declaration in support of family planning, called the "Fatwa."

In the Philippines, the new vice president had appeared in a series of television spots in support of family planning, despite the conventional wisdom in this heavily Catholic country that endorsing family planning hurts political careers. He got more votes than any other presidential or vice-presidential candidate.

Sports figures can also enhance the image of family planning through the mass media. In Pakistan, the national hero Imran Khan, captain of the world champion cricket team, lent his image and prestige to the celebration of the success of the popular family planning television series, "Aahat."

GOOD IMAGES AND BAD

The traditional image of promoting family planning is familiar from many posters: a large unkempt family contrasted with a small healthy one. Other common visuals are of an overcrowded city, school or public facility, with a warning of the dire consequences of overpopulation. Such messages may be educational, but research has shown that presenting negative images may not stimulate the desired action.

In contrast, promotional efforts in Turkey have portrayed family planning more positively, using the image of an elegant and respected actress, a role model for many women. Promotions in Hong Kong use the image of a Kung Fu master, highly esteemed in that society. Such images associate family planning with wisdom, *savoir-faire* and being modern — traits that many women and men can identify with and desire.

The benefits of family planning and spe-

cific contraceptives need to be supported with strategic communication and marketing plans. It would be inconceivable in the private sector to launch any major product without a corporate plan behind it. But that is exactly what has happened with almost all contraceptive products made available by international donors.

Advocates of family planning need to learn new ways of becoming more effective in protecting the health of mothers and children while promoting strong families.

— Jose G. Rimon II and Karungari Kiragu

Mr. Rimon is project director, Population Communication Services of the Johns Hopkins University (JHU/PCS) and deputy director of the Center for Communication Programs, in Baltimore, MD, USA. Dr. Kiragu is a research and evaluation officer at JHU/PCS.

FOOTNOTES

1. Unpublished study. For more information on how such survey data can be presented in a computer-generated process known as "perceptual mapping," contact Dr. D. Lawrence Kincaid at Johns Hopkins University, Center for Communication Programs, Baltimore, MD, USA.

2. Bashin M, Jato M. *Charting a Cause for Family Planning Communication in Cameroon. Focus Group Discussion Report.* Baltimore: The Johns Hopkins University, Population Communication Services, 1990.

3. *Platypus: Philippines Lifestyles project.* Report by Trends Inc. to The Johns Hopkins University, Population Communication Services, 1992.

4. Lozare BV, Loza S, Farag M, et al. An evaluation of clinic promotion activities in Egypt: the CSI experience. Paper presented at the 119th Annual Meeting of the American Public Health Association, Atlanta, GA, November 1991.



WINTHROP MORGAN

A FAMILY PLANNING ADVISERS' PARADE IN GHANA.

Resources

NETWORK INDEX AVAILABLE

An index to *Network*, FHI's quarterly bulletin on reproductive health, contraception and AIDS, is now available in English, Spanish and French.

Major articles from past issues through the end of 1992 are catalogued by subject, author and country. Indices may be obtained upon request from: Publications Assistant, Family Health International, P.O. Box 13950, Research Triangle Park, NC 27709 USA. Back copies of *Network* issues still in stock are also available in limited quantities, but requests for individual articles cannot be filled.

LISTING OF INTERNATIONAL NEWSLETTERS

The Appropriate Health Resources and Technologies Action Group Ltd, AHRTAG, has published a 1992-93 edition of *Resource List of Free International Newsletters*, a listing of 110 newsletters available at no charge to readers in developing countries. This 43-page booklet also includes 14 recommended newsletters and journals available by subscription. While free to people in developing countries, it costs U.S. \$3 for residents ordering from the United Kingdom, Europe or the United States. To order, contact: Margaret Elson, AHRTAG, 1 London Bridge St., London SE1 9SG, U.K. Telephone: 071-378-1403.

WOMEN'S HEALTH IN DEVELOPING WORLD

The International Women's Health Coalition, (IWHC) a U.S.-based non-profit organization dedicated to improving women's reproductive health in the developing world, has published reports on two recent meetings.

Special Challenges in Third World Women's Health, a second edition of a document originally published in 1990, contains presentations given at a panel convened at the 1989 Annual Meeting of American Public Health Association, which addressed reproductive tract infections (RTIs), cervical cancer and contraceptive safety.

Reproductive Tract Infections in Women in the Third World: National and International Policy Implications, authored by Adrienne Germain, IWHC's vice president, is a 28-page report based on papers and presentations given at

an international meeting of the same title, sponsored in 1991 by IWHC and The Rockefeller Foundation at the Bellagio Study and Conference Center in Italy.

This report is intended to encourage policy-makers, women's health advocates, service providers and researchers from both biomedical and social disciplines to take immediate action to break the "culture of silence" surrounding RTIs, and reduce the burdens they impose on women and on health systems. These infections cause widespread and preventable illness, infertility and death. The report concludes with a list of recommendations for action at the national and international levels. For copies of either report, both available in English only, contact IWHC, 24 E. 21 St., New York, NY 10010 USA. Telephone: (212) 979-8500.

Also, International Women's Health Coalition and the World Health Organization have jointly published *Creating Common*

News Briefs

(More news briefs on page 2)

U.S. FDA APPROVES DEPO-PROVERA

The U.S. Food and Drug Administration (FDA) has approved Depo-Provera, a progestin-only injectable administered every three months, for use as a contraceptive.

The October 1992 ruling followed 25 years of attempts by the manu-

facturer, Upjohn Co., to secure approval for the drug as a contraceptive in the United States. Depo-Provera is the registered name for depot medroxyprogesterone acetate, or DMPA.

The ruling has important implications for family planning internationally, says Dr. Sharon Camp, senior vice president of Population Action International. "This approval will provide the legal basis for using the drug in many countries that require a drug first be approved in the country of origin," she says. Moreover, the FDA approval means that the drug can be distributed in other countries by the U.S. Agency for International

Development, Dr. Camp says.

More than 11 million women in 90 countries have successfully used DMPA as a contraceptive. Although Depo-Provera had been approved for years for treating endometrial and renal cancers in the United States, research in the 1970s linking DMPA to increased risk of breast and cervical cancers prevented its approval for contraceptive use. More recent studies have not confirmed those research findings.

Depo-Provera is more than 99 percent effective in preventing pregnancy. It contains progestin, a synthetic hormone that suppresses ovulation and thickens

cervical mucus. Since there is no estrogen in Depo-Provera, it can be used by many women who cannot tolerate estrogen-containing methods, such as combined oral contraceptives or the new injectable Cyclofem.

Depo-Provera provides a useful option for women who want a reversible method but do not want to have to take a pill every day, or use a diaphragm or condom. Contraceptive protection begins within two weeks of the first injection. Fertility is restored usually within 10 months after quitting the method. Possible side effects include bleeding irregularities, weight gain, nausea and headaches.

Ground: Women's Perspectives on the Selection and Introduction of Fertility Regulation Technologies. This report compiles presentations and discussion comments from a 1991 meeting of women's health advocates and scientists designed to improve relations between institutions that formulate policy and the consumers affected by policy. The 45-page booklet, published by WHO's Special Programme of Research, Development and Research Training in Human Reproduction, includes recommendations for continued discussion and action at local, national and international levels. It is available at no charge from either IWHC at the above address, or Special Programme of Research, Development and Research Training in Human Reproduction, World Health Organization, 1211 Geneva 27, Switzerland.

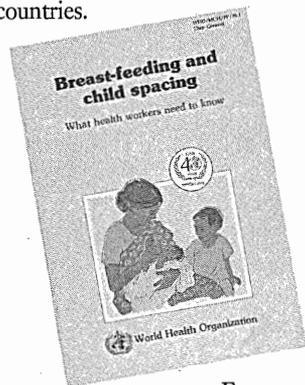
Also available from WHO is *Antenatal Care and Maternal Health: How Effective Is It?* A publication of the Maternal Health and Safe Motherhood Programme, the 80-page report examines the potential of antenatal interventions to reduce maternal mortality. Maternal mortality is the health indicator which shows the greatest differential between developed and developing countries, with the lifetime risk of pregnancy-related death estimated to be 500 times as high for women in Africa as for those in developed countries. Information about the scope for reducing this risk through family planning has been available, but the potential of antenatal care to reduce maternal deaths and serious illness arising from complications during pregnancy and childbirth in developing countries has not been systematically assessed, despite widespread belief that it can improve maternal health.

This report, designed to be a first step in a research program to explore this potential, provides a review of the effectiveness of antenatal interventions, suggestions about outstanding research ques-

tions and a bibliography on the subject. For more information, contact the Maternal and Child Health Unit, Family Health Division, World Health Organization, 1211 Geneva 27, Switzerland.

WHO BOOKLET ON BREASTFEEDING AND CHILD SPACING

Breastfeeding and Child Spacing: *What Health Workers Need to Know* is available from World Health Organization. This 27-page booklet is designed to give physicians and other health workers information on the relationship between breastfeeding and child spacing, particularly for those living in developing countries.



For more information, contact the Maternal and Child Health Unit, Family Health Division, World Health Organization, 1211 Geneva 27, Switzerland.

TWO NEW INTRAH PUBLICATIONS

Program For International Training in Health (INTRAH) has published its fifth edition of *List of Free Materials in Family Planning/Maternal and Child Health*. This 155-page resource is designed to help

inform training and service organizations in developing countries and international agencies of the large number and variety of free materials available from organizations around the world.

Also recently published by INTRAH, *French and English Glossary of Training Evaluation Terms* is a bilingual publication defining commonly used family planning and primary health care training and evaluation terms. Written as a reference for health professionals involved in training, the 100-page glossary is designed to define and promote standardization of terms frequently used by INTRAH in training.

To obtain either of these publications, contact: INTRAH, 208 N. Columbia St., Chapel Hill, NC 27514 USA.

GUIDE FOR FAMILY PLANNING EVALUATION

A new manual for family planning evaluation is designed to benefit both novice and expert evaluators. *Improving Family Planning Evaluation, A Step-by-Step Guide for Managers and Evaluators*, published in Spanish and English editions by Pathfinder International in 1992, offers practical analytical tools for helping decision makers to improve project design and implementation.

Authored by Jose Garcia Nuñez, Pathfinder's director of evaluation, this guide follows the evaluation process step-by-step, providing information about which evaluation methods satisfy the reporting needs of donors and constituents and how evaluations

are used in cost-effective project planning. The 200-page manual explains which evaluation techniques forecast program strengths and weaknesses, when and how to conduct evaluations, and who should be conducting them.

Pathfinder offers a limited number of these handbooks free of charge to family planning organizations in developing countries. To order Spanish or English versions, contact: Commodities Department, Pathfinder International, Nine Galen St., Suite 217, Watertown, MA 02172-4501 USA. Telephone: 617-924-7200, or fax: 617-924-3833. The Spanish version is also available by contacting PROFAMILIA/Colombia: PROFAMILIA (Attn: Evaluation & Research), Calle 34, No. 14-52, Bogota, DE, Colombia. Telephone: 5712-872-100 or fax: 5712-875-530.

New FHI Publications

To request any of the following publications, write to: Publications Assistant, Family Health International, P.O. Box 13950, Research Triangle Park, North Carolina, USA 27709. Please request publications by number.

- 92-25** Kennedy KI. The promotion of exclusive breastfeeding and the lactational amenorrhea method in NFP programs. In: Queenan GT, Jennings VH, Spieler JM, von Hertzen H. *Natural Family Planning: Current Knowledge and New Strategies for the 1990s, Proceedings of a Conference*, Washington, December 1-14, 1990, part 2. Washington: Institute for Reproductive Health; 1992.
- 92-26** Williamson N. A perspective on NFP and family planning programs. In: Queenan GT, Jennings VH, Spieler JM, von Hertzen H. *Natural Family Planning: Current Knowledge and New Strategies for the 1990s, Proceedings of a Conference*, Washington, December 1-14, 1990, part 2. Washington: Institute for Reproductive Health; 1992.
- 92-27** Rukanuddin R, Hardee-Cleaveland K. Can family planning succeed in Pakistan? *Int Fam Plann Perspect* 1992; 18 (3): 109-115, 121.
- 92-28** Thapa S, Kumar S, Cushing J, Kennedy K. Contraceptive use and needs among postpartum women in 25 developing countries: recent patterns and programmatic implications. *Int Fam Plan Perspect* 1992; 18 (3): 83-92.
- 92-29** Steiner M, Foldes R, Cole D. Study to determine the correlation between condom breakage in human use and laboratory test results. *Contraception* 1992; 46 (3): 279-88.
- 92-30** Hubacher D, Bailey P, Janowitz B, Barahona F, Pinel M. Estimating infant mortality prospectively in Honduras. *J Biosoc Sci* 1992; 24: 433-45.
- 92-31** Zhang J, Feldblum PJ, Chi I, Farr MG. Risk factors for copper T IUD expulsion: an epidemiologic analysis. *Contraception* 1992; 46 (6): 427-33.
- 92-32** PJ Feldblum, J Zhang, LE Rich, JA Fortney, RV Talmage. Lactation history and bone mineral density among perimenopausal women. *Epidemiology* November 1992; 3 (6): 527-31.
- 92-33** Chi I. The multiload IUD — A U.S. researcher's evaluation of a European device. *Contraception* 1992; 46 (6): 407-25.